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TRAUMA-INFORMED CASE MANAGEMENT PRACTICE FOR YOUTH EXPERIENCING HOMELESSNESS: CONNECTION, HEALING AND TRANSFORMATION

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TRAUMA-INFORMED CASE MANAGEMENT PRACTICE FOR YOUTH EXPERIENCING HOMELESSNESS: CONNECTION, HEALING AND TRANSFORMATION

Abstract

Young people experiencing homelessness in the United States are some of the most resilient individuals in our society. They, like all young people, are filled with extraordinary potential. However, the multiple and chronic trauma that these young people experience, caused by systemic injustices such as poverty, violence and oppression, both before and while experiencing homelessness, deeply violate their dignity and human rights. For youth experiencing homelessness, their very survival physically, mentally, emotionally, spiritually and economically is threatened daily. Experiences such as: abuse, neglect, poverty, housing instability, loss, family and community violence, victimization, exploitation, hunger, illness, criminalization, social isolation, rejection and marginalization profoundly influence a young person's sense of safety and ultimately their health and wellbeing. The purpose of this project is to create a response to youth homelessness that restores and enhances dignity and provides opportunities for *connection, healing and transformation*. This will be accomplished by the creation of a Trauma-Informed Case Management Toolkit for case managers working with youth experiencing homelessness. In short, this response addresses the individual needs of young people experiencing homelessness while also encouraging social change. The trauma-informed case management toolkit, a holistic guide in delivering case management services, connects theory to practice for case managers, infusing principles of trauma-informed care, attachment theory, youth development and social justice into case management practice with youth experiencing homelessness. The intention is that the trauma-informed case management toolkit can be used as part of the larger response in addressing youth homelessness from an individual, community, societal, and policy perspective.

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TRAUMA-INFORMED CASE MANAGEMENT PRACTICE FOR YOUTH
EXPERIENCING HOMELESSNESS: CONNECTION, HEALING AND
TRANSFORMATION

Frank McAlpin

A DISSERTATION

In

Social Work

Presented to the Faculties of the University of Pennsylvania

In

Partial Fulfillment of the Requirements for the

Degree of Doctor of Social Work

2018

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Dedication

This project is dedicated to all those working to end youth homelessness, especially the case managers, who everyday seek to support, empower, advocate and care for young people experiencing homelessness.

And to all the young people experiencing homelessness- whose strength, courage, compassion, openness, partnership, passion and resilience inspires our work together in ending youth homelessness.

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Finally, thank you to all the young people I have had the immense privilege to work with over the years. You have, without question “reached me”. I thank you for your openness, your voice, your partnership, your humor. And most of all your willingness to connect.

Abstract

Young people experiencing homelessness in the United States are some of the most resilient individuals in our society. They, like all young people, are filled with extraordinary potential. However, the multiple and chronic trauma that these young people experience, caused by systemic injustices such as poverty, violence and oppression, both before and while experiencing homelessness, deeply violate their dignity and human rights. For youth experiencing homelessness, their very survival physically, mentally, emotionally, spiritually and economically is threatened daily. Experiences such as: abuse, neglect, poverty, housing instability, loss, family and community violence, victimization, exploitation, hunger, illness, criminalization, social isolation, rejection and marginalization profoundly influence a young person's sense of safety and ultimately their health and wellbeing. The purpose of this project is to create a response to youth homelessness that restores and enhances dignity and provides opportunities for *connection, healing* and *transformation*. This will be accomplished by the creation of a Trauma-Informed Case Management Toolkit for case managers working with youth experiencing homelessness. In short, this response addresses the individual needs of young people experiencing homelessness while also encouraging social change. The trauma-informed case management toolkit, a holistic guide in delivering case management services, connects theory to practice for case managers, infusing principles of trauma-informed care, attachment theory, youth development and social justice into case management practice with youth experiencing homelessness. The intention is that the trauma-informed case management toolkit can be used as part of the larger response in addressing youth homelessness from an individual, community, societal, and policy perspective.

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Introduction

Young people experiencing homelessness in the United States are some of the most remarkably resilient individuals in our society and are filled with extraordinary potential. However, the realities that these young people experience, both before and while experiencing homelessness, deeply violate their dignity and human rights. Virtually all youth who end up on the streets have experienced multiple incidences of trauma in their lives including: abuse, neglect, victimization, exposure to violence, poverty, housing instability and loss (Bender Thompson, Yoder & Kern, 2014; Rabinovitz, Desai, Schneir & Clark, 2010). Once on the streets, their vulnerability increases drastically due to their young age and exposure to further traumas such as: hunger, exhaustion, illness, victimization, exploitation, criminalization, social isolation, marginalization and even death (Administration for Children and Families [ACF], 2016; Bender et al., 2014; Kidd & Davidson, 2007). For youth experiencing homelessness, their very survival physically, mentally, emotionally, spiritually and economically is threatened daily.

Youth homelessness is a complex social problem that is created and exacerbated because of systemic injustices throughout society. These injustices, particularly poverty, violence and oppression, and the attitudes, systems and policies that further them must be exposed, challenged and dismantled. Furthermore, the impact of trauma on young people, including that perpetrated by systemic injustices, influences all aspects of their lives, requiring a response that is holistic and comprehensive (Courtois & Ford, 2013; Hopper, Bassuk, & Olivet, 2010; McKenzie-Mohr, Coates, McLeod, 2012).

The purpose of this project is to create a response to youth homelessness that restores and enhances dignity and provides opportunities for connection, healing and transformation. It is a response that addresses the individual needs of young people while also encouraging social

change. It also is a response that honors the inherent dignity of these extraordinary young people, their immense strengths and talents, and the amazing potential they possess to transform their lives and our society. This response will be accomplished by the creation of a **trauma-informed case management toolkit** to be used by case managers working with youth experiencing homelessness. In short, the project seeks to connect theory to practice for case managers, enriching the case management services provided to young people experiencing homelessness. It is my hope that this trauma-informed toolkit, a holistic and practical guide in delivering case management services, will be used as part of the larger response in addressing youth homelessness from an individual, community, societal, and policy perspective.

Project Inspiration

In creating this project, I was inspired by three overall concepts/philosophies: *grassroots social work practice, the therapeutic value in all interactions and a case management paradigm shift*. These three concepts/philosophies embedded throughout the project are central to my own practice as a social worker, and particularly inform my work with youth experiencing homelessness.

Grassroots Social Work Practice:

The development of this project is born out of my deep commitment to grassroots social work practice. I believe grassroots social work practice to be a practice that is sensitive and responsive to the needs of people and communities on both an individual and global level, paying particular attention to social justice and human rights. This type of practice values community-based work including case management, crisis support, youth advocacy, program development, community organizing and social action, and intentionally and aggressively works to dismantle systemic injustice, such as oppression and poverty. At its core, grassroots social

work practice promotes and enhances the connection between people and communities through human engagement, mutual respect and understanding and a willingness to build and sustain authentic relationships. Most especially, this practice embraces self-awareness, engagement, participation, empowerment, solidarity and social change, values that are at the core of this project and values imperative in ending the epidemic of youth homelessness.

All Interactions Can Be Therapeutic

In providing case management services to young people experiencing homelessness, I have come to believe that virtually all interactions with young people - crisis counseling, developing a safety plan, accompanying them to a doctor's appointment, teaching them how to cook or playing a game with them - can be therapeutic. At the heart of these "therapeutic" interactions, is the intent to ensure that youth experience a genuine and safe human connection with their case managers, one that honors their dignity and could help them in the healing process. Furthermore, these "therapeutic" interactions can be transformative, not only for the young person, but for the case manager as well. As a case manager myself, I have found that it is the more "untraditional" everyday interactions (i.e. going on a hike with a youth or playing a game of UNO), which deepen my connection with a particular young person and have a lasting impact. This level of engagement with youth has ultimately helped me be a more authentic, intentional and effective, and even inspired case manager.

Case Management Paradigm Shift

The trauma-informed case management toolkit is designed to redefine what it means to provide case management services to youth experiencing homelessness. The toolkit is much more than a simple set of "tools" to use in case management with young people. Ultimately, the goal of this toolkit is to encourage an actual paradigm shift in the way case management services

are valued, conceptualized and applied to youth experiencing homelessness. This paradigm shift is one in which the “process” of case management, that is, the actual engagement and “work” that happens between the young person and the case manager, becomes just as significant, and possibly even more significant, than the accomplishment of any particular outcome. For example, in my experience, the work that is done in the course of assisting a young person in getting a part-time job - such as establishing a trusting relationship, helping them develop employment skills and supporting them through all aspects of the job application process – is just as meaningful and important for the young person, as whether or not that young person actually obtains a particular job.

In other words, establishing a connection with a young person matters. Ultimately, this paradigm shift in case management, from a task orientation to a process orientation that emphasizes connection, healing, and transformation, is rooted in a trauma-informed practice. It is a paradigm shift that incorporates both grassroots social work practice and the belief that every interaction we have with youth can be therapeutic. I have found that all three of these concepts/philosophies- *grassroots social work practice, the therapeutic value of all interactions and a case management paradigm shift* - help create social change and ultimately will help to end youth homelessness.

Project Organization:

This project is broken into two parts. The first part is a series of chapters that explore and present existing literature and best practices, with regard to addressing youth homelessness, and provides the theoretical foundation for the toolkit. The second part of this project is the toolkit itself. Throughout the following chapters, case examples will help to highlight the concepts presented and illustrate the application of established theory as it relates to providing case

management services to youth experiencing homelessness. These case examples represent the stories of actual youth experiencing homelessness. **All names and specific identifying information have been changed or altered to protect the identity and privacy of these young people.**

Federal Framework to End Youth Homelessness

In 2013, informed by the literature and experts in the field, the United States Interagency Council on Homelessness (USICH) developed a “Framework to End Youth Homelessness”. Within this framework, four core outcomes related to ending youth homelessness were identified: *1.) stable housing, 2.) permanent connections, 3.) education and employment and 4.) social-emotional wellbeing* (USICH, 2013). This project incorporates these four desired outcomes, as they are directly relate to outcomes and goals within case management. It cannot be ignored that according to USICH, as well as to many youth experiencing homelessness service providers and activists working with youth experiencing homelessness, that these four outcomes are crucial in transitioning youth from the streets and into more stable housing, ultimately helping to end youth homelessness (USICH, 2013).

“Youth Experiencing Homelessness”

The language we use in society to describe individuals and communities is important, as it often influences how we view these individuals and communities, and subsequently impacts our attitudes, values and social policies. Nowhere is this truer than the naming and describing of youth experiencing homelessness, individuals who are already deeply marginalized in our society. In naming and describing youth experiencing homelessness, the phrase “youth experiencing homelessness” (or some variation) rather than “homeless youth” is used intentionally throughout this project. While “youth experiencing homelessness” might seem

“wordy” or cumbersome grammatically, it helps to advance language, that is less stigmatizing and more “person-centered” in referring to these young people and may actually influence our collective attitude. Furthermore, this language reinforces what many youth experiencing homelessness, service providers, and advocates know to be true- “homelessness” is not someone’s identity but rather a situation and represents not what is wrong with them, but rather what happened to them.

Key Terminology and Concepts

Youth Experiencing Homelessness: any unaccompanied youth (a youth outside the care and supervision of an adult guardian, including youth out of the supervision of child welfare or juvenile justice), ages 12-24 years old who lacks a safe, stable and/or permanent living space (Morton, Dworsky & Samuels, 2017; National Network 4 Youth [NN4Y], 2015).

Trauma-Informed Care: an approach that seeks to recognize, understand and respond to the impact that trauma, particularly complex trauma, has had on the lives of young people (Hopper et al., 2010; SAMHSA, 2014) with the overall goal in establishing safety, both physically and emotionally, for youth and case managers and moving youth towards a place of healing and empowerment (Bender et al., 2014; Coates & McKenzie-Mohr, 2010; Hopper et al., 2010).

Case Management: services and interventions that are strengths-based and grounded in the relationship between the youth and case manager including: outreach and referrals, connection to public and community-based resources, assistance in coordinating services, family reunification, safety planning, crisis intervention, job readiness and training, housing navigation, life skills development, leadership development and social activism (ACF, 2016; Aviles & Helfrich, 2004; Thompson et al., 2006).

Youth Experiencing Homelessness: Background, Pathways, Characteristics and Critical Issues

By the time Charlie turned 20 years old, he had been experiencing homelessness for close to five years. Charlie grew up in a small Southern town, in extreme poverty, often not having enough food to eat. He was subjected to intense emotional abuse at the hands of his mother and other extended family members living in the home. As a young teenager, he was sexually abused several times by his pastor and close family friend. At 15 years old, Charlie, who always felt different, finally came out as gay, after which the emotional abuse from his family intensified so much he eventually left home. For the next year Charlie couch surfed, staying with different friends from school for a short periods of time. When he ran out of friends to stay with and with nowhere to go, he would return to his mother's home and then the cycle of couch surfing would repeat. At some point child welfare was called but an investigation found no reason to remove Charlie from the home. Shortly after turning 16 years old, after an extremely violent attack by an older relative, which his mother encouraged, Charlie left home for good, ultimately ending up hundreds of miles away in one of the nation's largest cities.

After a few days of living on the streets, sleeping in doorways and on park benches, in a city he didn't know, he found a youth shelter. After arriving at the youth shelter, he quickly learned that if he wanted to stay there for longer than a few days, the authorities would have to be contacted. Not wanting to be returned to his mother's care or put into foster care, Charlie only stayed at the shelter one night, after which he was back out on the streets. On streets, he quickly discovered that he could have sex with people for a place to sleep. For the next several years Charlie would engage in "survival sex" (although due to his age, some might call it

“survival rape”). During this time, Charlie also became involved in a physical and emotionally abusive relationship with an older man, who eventually got him addicted to meth.

Homeless on the streets Charlie experienced much victimization, exploitation and trauma. He witnessed extreme violence and trauma, including people being stabbed and shot. He developed significant mental health issues, including PTSD symptoms. During this time, he was detained by both the juvenile and criminal justice system. And as a young gay Black male, Charlie experienced much discrimination and oppression, from individuals and systems. Like many youth experiencing homelessness, Charlie cycled in and out youth drop-in centers and youth shelters. He would often use these spaces as a means of taking a “break” from street life, as they had become safe spaces for him to rest and be cared for. These spaces and the staff he interacted with in them treated Charlie with compassion, affirming and accepting him for who he was in the moment. And by age 20, after years of being on the street, it was his connection with these youth services that ultimately helped him feel comfortable enough to seek out help from them, which ultimately allowed for him to transition off the streets and into a supportive housing program, where he finally began to stabilize and address some of his challenges.

Systemic Injustice and Youth Homelessness

Charlie is just one of the millions of youth that experience homelessness every year. The increasing epidemic of youth homelessness, and the trauma that youth, like Charlie are exposed to both before and while experiencing homelessness, is a massive social injustice and a gross violation of human rights. The pathways that lead young people to experience homelessness as well as the critical issues impacting young people while experiencing homelessness are all results of systemic injustice (Hopper et al., 2010; McKenzie-Mohr et al., 2012; Wheeler, Price & Ellasante, 2017). The systemic injustices pervasive in society, such as poverty, violence and

oppression, often intersect and are at the root of much of the trauma and distress that young people, like Charlie experience both before and while experiencing homelessness (McKenzie-Mohr et al., 2012). Our role as case managers working with youth experiencing homelessness requires us to provide services and support to youth individually, while also working to dismantle the systemic injustices that fuel the youth homelessness epidemic.

Prevalence and Definition of Youth Experiencing Homelessness

For researchers, policy makers and activists getting an accurate count of the actual number of young people who experience homelessness or housing instability has always been a challenge (ACF, 2016; Morton, Dworsky, Samuels, 2017). Youth experiencing homelessness do not always self-identify as “homeless” or seek “homeless” specific services. These young people often go unseen and unaccounted (Morton et al., 2017).

However, in late 2017, a landmark report issued by University of Chicago’s Chapin Hall found that close to 4 million youth experience some form of homelessness over a given year (Morton et al., 2017). Specifically, Chapin Hall’s report, *Missed Opportunities: Homelessness in America*, found that “one in 10 young adults ages 18-25, and at least one in 30 adolescents ages 13-17, experience some form of homelessness unaccompanied by a parent or guardian over the course of a year” (Morton et al., 2017). In Los Angeles, the nation’s epicenter of homelessness, the 2017 Youth Count Survey conducted by the Los Angeles Homeless Service Authority, found there were close to 6,000 youth experiencing homelessness on any given night in the city (Los Angeles Homeless Service Authority, 2017). The high prevalence of youth amongst the larger homelessness population was underscored in a 2014 Housing and Urban Development (HUD), report which found 34% of individuals experiencing homelessness in the U.S. were under the age of 24 years old (Housing and Urban Development, 2015).

For purposes of this project “homeless youth” are defined as any unaccompanied youth (a youth outside the care and supervision of an adult guardian, including youth out of the supervision of child welfare or juvenile justice), ages 12-24 years old who lacks a safe, stable and/or permanent living space (Morton et al., 2017; National Network 4 Youth [NN4Y], 2015). This definition of youth experiencing homelessness includes youth sleeping on the streets, running away, being kicked out, residing in an emergency shelter, transitional living program or supportive housing program, living out of a car or a hotel and/or couch surfing (ACF, 2016; Coats & McKenzie-Mohr, 2010; Kidd & Davidson, 2007; Morton et al., 2017; Thompson, Safyer & Pollio, 2001). It should be noted that a large majority of youth experiencing homelessness experience a combination of the above situations (i.e. sleeping on the street, residing in a shelter, couch surfing, etc.) over their time of experiencing homelessness. This conceptualization of who is a “homeless youth” is intentionally inclusive and comprehensive and honors the complex and varied lived realities of youth experiencing homelessness in our society (ACF, 2016; Kidd & Davidson, 2007; Morton et al., 2017). In addition, the broad age range (12-24 years old) is sensitive to the reality that the majority of youth experiencing homelessness agencies and programs aim to provide services to youth within this age range.

Pathways for Youth Experiencing Homelessness

There are often multiple, intersecting and concurrent drivers of youth homelessness. Two of the most common pathways that lead youth to experience homelessness are *family dysfunction* and *system failure* (National Alliance to End Homelessness, 2010; National Childhood Traumatic Stress Network [NCTSN], 2007; NN4Y, 2015; Rabinovitz et al., 2010). “Family dysfunction” broadly refers to the circumstances youth experience, within their families and/or home that cause physical or emotional harm and force them to runaway, be thrown out or

removed from their homes. “System failure” broadly refers to systems of care, particularly child welfare and juvenile justice, and their failure to provide appropriate care while youth are within those systems as well as support when youth exit those systems. While youth experiencing homelessness might not always report past abuse and/or involvement in the child welfare/juvenile justice, and connect those experiences to their experience of homelessness, the literature strongly indicates that youth experiencing homelessness have almost always experienced some form of family dysfunction and/or a system failure before ending up on the streets (Coates & McKenzie-Mohr, 2010; Ferguson, 2009; NCTSN, 2007; NN4Y, 2015; Petering, 2017; Rabinovitz et al., 2010; Whitbeck, Hoyt & Bao, 2000). In addition to family dysfunction and system failure, research, as well as experience in the field, suggests that social problems and policies such as: poverty, housing instability, community violence, criminalization and immigration can also lead young people to experience homelessness (Berg, 2016; NN4Y, 2015; Petering, 2017; Wheeler et al., 2017).

Family Dysfunction

“Family dysfunction” is most commonly associated with abuse and/or maltreatment that youth experience within their family structure. Youth experiencing homelessness have extremely high incidences of abuse and maltreatment growing up, which forces many of them to “runaway” from home or become involved in the child welfare and/or juvenile justice systems (ACF, 2016; Coates & McKenzie-Mohr, 2010; Ferguson, 2009; NN4Y, 2015, Whitbeck et al., 2000). Rabinovitz et al. (2010) maintain that most studies have found that youth experiencing homelessness have experienced, in their own homes, rates of physical abuse between 40% and 60% and sexual abuse between 17% and 35% (NCTSN, 2007; Rabinovitz et al., 2010). A study that surveyed youth experience homelessness in three major cities around trauma experiences,

found that the most common form of trauma before leaving home was emotional neglect (93%), followed by emotional abuse (91%), physical neglect (87%), physical abuse (83%) and sexual abuse (36%) (Bender et al., 2014). In another study that identified six types of abuse, *verbal abuse, emotional abuse, physical abuse, sexual abuse, witnessing family verbal abuse and witnessing family physical abuse*, Ferguson (2009) found that 71% of youth experiencing homelessness reported three or more types of abuse before experiencing homelessness, while 18% reported five or six types of abuse (Ferguson, 2009).

In addition to abuse, dysfunction within the family also includes maltreatment, parental substance use or mental illness, parental incarceration, sexual exploitation, domestic violence and parental illness (ACF, 2016; Coates & McKenzie-Mohr, 2010; NCTSN, 2007; Petering, 2017; Rabinovitz, et al., 2010). Research done with youth experiencing homelessness in Hollywood, California found that outside of physical and sexual abuse, 34% of young people reported neglect, 15% were involved in drug sales by their parents/caregivers and 6% were commercially sexually exploited by their parents/caregivers before experiencing homelessness (Rabinovitz, et al., 2010). Another form of family dysfunction is family conflict, which generally refers to conflict, tension or extreme disagreements between young people and their parents/caregivers that result in young people running away from home or being kicked out of their homes. The most common conflicts or tensions causing a young person to experience homelessness are identity rejection (being rejected due to sexual orientation or gender identity), a young person's substance use or engagement in other high risk behaviors, delinquency and/or not following parental rules/limits (NCTSN, 2007; Thompson et al., 2010; Wheeler et al., 2017).

System Failure

“Family dysfunction”, such as abuse, neglect, parental substance use and parental incarceration, along with a caretaker’s inability to cope/manage stress, behavior problems, inadequate housing and abandonment, have been found to be top reasons young people enter system care (Thompson, Bender, Windsor, Cook & Williams, 2010; U.S. Department of Health and Human Services, 2017). In 2016, the Administration for Children and Families (ACF) conducted a national study of young people accessing street outreach programs and found that about half of young people experiencing homelessness had a history of child welfare involvement (ACF, 2016). In another study out of Hollywood California, 48% of youth experiencing homelessness reported having some involvement in child welfare, with 40% of youth reporting that they were removed from their home and placed into foster care (Rabinovitz, et al., 2010). In addition to child welfare, system failure also refers to the criminal justice system, both juvenile as well as the adult system, which fails to provide adequate care and/or support for young people after their involvement in the system often causing those youth to have an increased risk of experiencing homelessness (Coalition for Juvenile Justice, 2017; Morton et al., 2017; NN4Y, 2015; Sermons & Witte, 2011).

The realities of system-involvement that include youth with complex trauma histories, multiple foster care placements, inappropriate and/or non-affirming placements, running away from placements, juvenile detention, disruptions in schooling, “aging-out” of care with limited resources and support and history of abuse and neglect, including being abused and victimized while in system care, greatly heighten the risk for system-involved youth to experience homelessness (Bender, Yang, Ferguson & Thompson, 2015b; Berg, 2016; Dworsky, Napolitano, & Courtney, 2012; Petering, 2017; Wheeler et al., 2017). In addition, just as youth homelessness is linked to larger systemic injustices, so too is a youth’s involvement in child

welfare and/or juvenile justice systems (Wheeler et al., 2017). Wheeler et al., (2017) states that “the failures of the foster care system are the result of oppressive societal forces such as racism, classism and heterosexism that are inherently woven into the fabric of the system. These systems of oppression have led to a disproportionate representation of youth of color, families living below the poverty line and LGBTQ young people in the system” (p. 55). It cannot go unnoticed that these groups of youth (i.e. youth of color, LGBTQ youth) are also overrepresented in the youth experiencing homelessness population as well (Morton et al., 2017).

Social problems and policies

In conjunction with family dysfunction and system-failure, social problems such as poverty, income inequality, community violence, gang activity, mass incarceration and immigration can all be drivers of youth homelessness (Berg, 2016; Morton et al., 2017; NN4Y, 2015; Petering, 2017; Wheeler et al., 2017). In my work with young people experiencing homelessness, I have seen all too often how social problems and policies have impacted individual young people, often leading them to experience homelessness. I have worked with youth who became homeless because their undocumented parent was detained and deported, youth who once they turned 18 years old were forced to leave the housing program they were living in with their family, youth who leave their neighborhood because of community violence or to avoid joining a gang and youth who once they are released from jail/prison have limited or no access to quality employment, limiting their ability to earn an income, thus afford housing. Some of society’s most controversial issues including immigration policy, social welfare, affordable housing and criminal justice reform, often have very real consequences for many young people. In fact, society’s unwillingness or inability to find humane and just solutions to

these “controversial issues” not only drives young people to experience homelessness but also can trap them in it, further perpetuating trauma and injustice.

Youth Experiencing Homelessness: Over-represented Populations

Youth experiencing homelessness come from a diverse array of racial and ethnic backgrounds, social identities, regions of the country and life circumstances. In short, the diversity of young people experiencing homelessness across the country is vast. However, research indicates that certain groups of young people are overrepresented amongst the population of youth experiencing homelessness. LGBTQ youth, youth who have “aged-out” of foster care and youth of color all are grossly overrepresented amongst the youth experiencing homelessness population (ACF, 2016; Durso & Gates, 2012; Morton et al., 2017; Petering, 2017). In conjunction with the complex trauma many of these young people have experienced, being a member of at least one of these groups, heightens the risk of those young people not only experiencing homelessness, but of staying homeless longer than those youth not members of these groups (ACF, 2016; Dworsky et al., 2013; Ray 2006).

LGBTQ Youth

While family conflict, abuse, poverty and involvement in child welfare and juvenile justice systems are common experiences for all youth experiencing homelessness, when experienced by LGBTQ youth these circumstances have a greater likelihood to lead these youth to experience homelessness (Choi, Wilson, Shelton & Gates, 2015). It is estimated that LGBTQ youth have a 120% increased risk of experiencing homelessness compared with their straight and/or cisgender peers (Morton et al., 2017), thus studies have found close to 40% of youth experiencing homelessness identify as LGBTQ (Durso & Gates, 2012). LGBTQ youth’s large representation within the youth experiencing homelessness population is often the result of

family conflict, particularly family rejection due to a youth's sexual orientation or gender identity, leading the youth to be kicked out or asked to leave their home (Ray, 2006). In other circumstances, LGBTQ youth are made to feel so uncomfortable, unsupported, unwanted and/or unloved by their parents/family, they decide to leave their home. Durso & Gates (2012) found that of LGBTQ youth experiencing homelessness, 46% reported they ran away from home, while 43% of youth reported they were forced by their parents to leave home due to their sexual orientation or gender identity. Along with conflict, tension and rejection within the family environment, LGBTQ youth often face hostile, unsupportive and/or unsafe schools, churches, neighborhoods, group homes and foster care placements, all of which contribute to LGBTQ youth experiencing homelessness (Berg, 2016; Wheeler et al., 2017)

LGBTQ youth are also disproportionately involved in the child welfare and/or juvenile justice systems, thus placing them at further risk to experience homelessness as involvement in these systems increases the likelihood a youth will experience homelessness (Berg, 2016; Dank et al., 2015; Wilson, Cooper, Kastanis & Nezhad, 2014). In Los Angeles County, a recent study found that close to 20% of youth in foster care identified as LGBTQ (Wilson et al., 2014). In addition, LGBTQ foster youth in LA County were twice as likely to reside in a group home, rather than an individual foster home and had a higher number of placements (i.e. multiple living situations) while in care, both of which result in a greater likelihood of instability (Wilson et al., 2014). LGBTQ youth involved in the child welfare system are often placed in group homes or foster care placements that are not LGBTQ affirming or supportive and thus youth experience hostility, disrespect and even abuse, leading many LGBTQ foster youth to run away from placements, thus becoming homeless (Dank et al., 2015). The pervasiveness of this reality is

highlighted in one report which found 78% of LGBTQ in care were removed or ran away from their placement due to hostility or harassment (Laver & Khoury, 2008).

Former Foster Youth

As indicated earlier, system involvement is a major pathway for youth in experiencing homelessness, thus it is no wonder youth with a history of child welfare placement, and specifically youth who “age-out” of foster care are overrepresented within the youth experiencing homelessness population (Bender et al., 2015b; Dworsky & Courtney, 2009). The term “age-out” refers to the age (either 18 or 21 years old depending on the state) in which young people are no longer in the care of and thus the responsibility of the child welfare system (Berg, 2016). Estimates indicate that between 31-46% of foster youth have experienced a period of homelessness after aging out of care (Dworsky et al., 2013). Often referred to as “former foster youth”, these young people lack the financial stability, basic life skills and permanent connections, such as family, needed to assist them in transitioning to independence, thus they are at heightened risk of experiencing homelessness (Bender, et al., 2015b; Dworsky & Courtney, 2009). Foster care-involved youth, have been found to have highly complex trauma histories and report a high frequency of physical abuse, physical neglect and sexual abuse, all of which are linked with increased likelihood in experiencing homelessness (Bender et al., 2015b). On average former foster care youth remain homeless a year longer than youth experiencing homelessness with no foster care history (Bender, et al., 2015b), and experience high rates of emotional distress, substance use, victimization, sexual exploitation and criminalization during episodes of homelessness (ACF, 2016; Bender et al., 2015b; Dank et al., 2015).

Youth of Color:

The overrepresentation of youth of color, particularly Hispanic and Black/African American youth, among the youth experiencing homelessness population is directly linked with systemic racism and oppression. Chapin Hall's 2017 report on youth experiencing homelessness found that Hispanic youth had a 33% higher risk of experiencing homelessness, even though in 2014 only 19 % of youth served by federally funded youth experiencing homelessness programs identified as Hispanic (Morton et al., 2017). This reality, points to a large disparity among Hispanic youth experiencing homelessness and their access/use of youth experiencing homelessness services and leads Morton et al. (2017) to assert that "Hispanic youth are especially hidden among those experiencing homelessness" (p.13). In my experience, the "hidden-ness" of any group of youth places them at heightened risk for victimization and exploitation and further disconnects them from housing, healthcare, education and employment, all of which increases their vulnerability and marginalization. Morton et al. (2017) report that Black/African American youth are grossly overrepresented among the youth experiencing homelessness population, having an 83% higher risk of experiencing homelessness. Morton et al. (2017) assert "disproportionality of homelessness experiences among black youth mirrors racial disparities documented elsewhere, for example in school suspensions, incarceration and foster care placement" (p. 12) again highlighting the role of oppression in the youth homelessness epidemic.

Trauma: Ultimate Pathway of Youth Homelessness

The experience of trauma in a young person's life, often the result of family dysfunction, system failure and/or the impact of social problems and policies, is central to the reason a young person experiences homelessness in the first place. And trauma, in its various forms, can be a daily occurrence once youth are on the streets. Thus, for young people experiencing

homelessness, trauma is both a cause and consequence of homelessness (Bender et al., 2014; Coates & McKenzie-Mohr, 2010; Hopper et al., 2010; Rabinovitz, et al., 2010). Coats & McKenzie-Mohr (2010) found that on average youth experiencing homelessness reported 11-12 various forms of trauma, around half experienced before actual homelessness and half experienced during their experience of homelessness (Coats & McKenzie-Mohr, 2010).

Once experiencing homelessness, youth are exposed to and often experience multiple and extreme forms of trauma including victimization, sexual exploitation, hunger, exhaustion, harassment, illness, violence and even death (Bender et al., 2014; Goodman, Saxe & Harvey, 1991; Hopper et al., 2010; Rabinowitz et al., 2010). A study examining the trauma experiences of youth experiencing homelessness in three major cities found on average young people experienced three types of trauma while on the street, yet close to 20% of youth reported experiencing four types of trauma (Bender et al., 2014). Bender et al (2014) found the most common types of trauma while on the street were: death of a close friend or family member, witnessing and/or experiencing violence, witnessing someone over-dose on drugs and being physically threatened (Bender et al., 2014).

Furthermore, homelessness in itself is traumatic (Goodman et al., 1991; Hopper et al., 2010). The reality of being homeless, of not having a “home” and all that comes with that reality, including the psychological impact of instability, the exposure to trauma, stigma, discrimination and marginalization and coping with street or “homeless shelter” life, all are experienced as traumatic by youth (Coates & McKenzie-Mohr, 2010; Goodman et al., 1991). Furthermore, Goodman et al. (1991) maintain that the experience of homelessness can also exacerbate already existing emotional distress and mental health symptoms and/or substance use a young person might already have (Goodman et al., 1991). The social stigma and

marginalization of those experiencing homelessness on both an individual and systemic level, often experienced through attitudes and social policies, often heighten the trauma experienced by those experiencing homelessness, making the experience of “homelessness” even more traumatic for youth (Goodman et al., 1991; Toolis & Hammack, 2015). Please note, more fulsome discussion of trauma, particularly complex trauma and its impact on youth experiencing homelessness will be presented in detail in a later chapter.

Critical Issues Impacting Youth Experiencing Homelessness:

Much of what a young person experiencing homelessness witnesses, is exposed to, engages in and/or experiences while homeless, either causes further trauma or is a response to trauma itself (Bender et al., 2014; Coates & McKenzie-Mohr, 2010; Courtois & Ford, 2013). Thus, Hopper et al. (2010) maintains “we are unable to solve the issue of homelessness without addressing the underlying trauma that is so intricately interwoven with the experience of experience of homelessness” (p. 81). The issues highlighted below are in no way intended to represent an inclusive list of the issues that impact youth experiencing homelessness, but rather represent the most common issues, as reflected in the literature as well as in my own experience working with young people experiencing homelessness (Bender et al., 2014; Bigelsen, 2013; Rabinovitz, et al., 2010; Thompson et al., 2010). Not only are these issues a cause and/or consequence of experiencing homelessness but also serve to reinforce each other. These issues can also directly influence young people’s ability and/or motivation to obtain stable housing, develop permanent connections, focus on education and employment and enhance their own social-emotional wellbeing, thus trapping them in the cycle of homelessness (Bender et al., 2014; Hopper et al., 2010; McManus & Thompson, 2008). It is imperative that case managers not only

recognize and understand the critical issues impacting youth experiencing homelessness but also assist youth in addressing these issues within the case management relationship.

Education and Employment

The realities of homelessness, instability, hunger, lack of rest, and trauma, all greatly influence a youth's education. The Chapin Hall report found that lack of education placed youth at higher risk of experiencing homelessness, highlighting that youth who had not obtained a high school diploma or GED were 4.5 times more likely to experience homelessness (Morton et al., 2017). Literature indicates experiencing homelessness can take a toll on youth's learning while in school, particularly effecting their ability to concentrate and pay attention (Institute for Children, Poverty & Homelessness- ICPH, 2017). Young people experiencing homelessness are more likely to report learning difficulties, causing them to be placed into special education classes, and are found to have high rates of emotional and disciplinary problems, leading them to be suspended or expelled (Bridgeland, Reed, Harrison & Raikes, 2016; Rabinovitz, et al., 2010; Shillington, Bousman & Clapp, 2011). Furthermore, young people who experience homelessness are found to have inconsistent school attendance, including multiple absences and frequent changes in schools, thus resulting in prolonged and reoccurring disruptions in their education, negatively impacting their learning, social development and contributing to their extremely high drop-out rates (America's Promise, 2014; Bridgeland, et al., 2016). Burt (2007) estimates that at least half of youth experiencing homelessness do not graduate from high school (Burt, 2007).

The experience of homelessness also greatly impacts a young person's ability to obtain and sustain quality employment. There are many factors that lead youth experiencing homelessness to be unemployed or underemployed, chief among them is their experience of

homelessness. The realities that experiencing homelessness presents, including housing instability, limited or no access to facilities to shower or sleep safely, inability to afford appropriate clothing for work and having to comply with strict curfew rules at shelters and housing programs, pose significant challenges to obtaining and sustaining employment. Rabinovitz et al. (2010) found that around 60% of youth over 18 years old experiencing homelessness in Hollywood were unemployed, while the ACF (2016) study found that just over 40% of youth experiencing homelessness had applied for a job in the last week (ACF, 2016; Rabinovitz et al., 2010). In addition, young person's educational deficits greatly influence to their ability to obtain employment and impacts how much they earn once they obtain a job (NN4Y, 2015). The American Human Development Project (2009) found that an individual without a high school diploma, which is the case for many youth experiencing homelessness, is four times as likely to be unemployed than a person with a college degree (American Human Development Project, 2009).

Furthermore, in my experience, even when youth experiencing homelessness can obtain employment, which is almost always a result of them first securing a more stable living situation, these young people struggle in the work environment. In my observation, the struggles that youth have in a work environment such as emotional dysregulation, limited life and social skills/competencies and inappropriate boundaries, often put them at risk for a reduction in their already limited hours or being terminated from the job all together. It cannot go unnoticed that much of the struggles mentioned above stem from impairments caused by complex trauma, underscoring the significant and lasting impact that complex trauma has on youth development and their overall wellbeing, such as obtaining and sustaining employment.

Emotional Distress and Mental Health

Research indicates that young people experiencing homelessness have high rates of emotional distress, as well as serious ongoing mental health conditions (ACF, 2016; Kidd, 2004; Rabinovitz, et al., 2010; Whitbeck, Hoyt, Johnson & Chen, 2007). Young people themselves have cited their experiencing homelessness as having a negative impact on their mental health (Bridgeland, et al., 2016). The most common mental health conditions youth experiencing homelessness present with are anxiety, depression, post-traumatic stress disorder (PTSD) and personality disorders (ACF, 2016; Bender et al., 2014; Thompson et al., 2010; Whitbeck et al., 2007). One national study found around 60% of homeless youth reported high levels of depressive symptoms and close to 80% of youth reported symptoms of PTSD (ACF, 2016). Whitbeck et al. (2007) found that just over one third of youth experiencing homelessness met the lifetime criteria for PTSD and virtually all of those young people met the criteria for an additional mental health diagnosis (i.e. depression, substance use, etc.) (Whitbeck et al., 2007).

In examining the emotional state of youth experiencing homelessness as it relates to suicidality, researcher Sean Kidd (2004), found that youth often feel a sense of “worthlessness, loneliness and hopelessness” (p. 46). To cope with the emotional stress of homelessness, youth often rely on maladaptive coping methods such as self-harming behaviors, including suicide, and hard drug use, which often fuels further emotional issues (ACF, 2016; Kidd, 2004; Thompson et al., 2010). Many researchers as well as youth service providers believe trauma both before experiencing homelessness and during the period of homelessness, is at the root of much of the emotional distress and thus mental health conditions young people experience (Bender et al., 2014; Coats & McKenzie, 2010; Whitbeck et al., 2007). Trauma, particularly complex trauma, which causes much of the emotional distress experienced by youth, greatly impacts normative

development and essential functioning and wellness for youth, all of which will be discussed in detail in a later chapter.

Substance Use

Developmentally, young people are more likely to experiment and use substances, such as alcohol and drugs, however youth experiencing homelessness often begin using substances earlier in life and report twice as much substance use as youth who do not experience homelessness (Johnson, Whitbeck & Hoyt, 2005; Slesnick, Meyers, Meade & Segelken, 2000). One study found 73% of youth had used alcohol, 64% had used marijuana and 37% had used “hard drugs” (i.e. cocaine, heroin and/or methamphetamine) within the last year (ACF, 2016). Another study of youth experiencing homelessness found that close to 50% of youth had used methamphetamine in their lifetime (Shillington et al., 2011). A 2005 study found that 60% of youth experiencing homelessness met the lifetime criteria for either alcohol abuse, alcohol dependence and/or drug abuse and virtually all those young people also had a diagnosed mental health condition (Johnson et al., 2005). For many youth experiencing homelessness their substance use is a way to cope with the daily realities of homelessness and/or self-medicate due to the extreme trauma they have experienced and the emotional stress that trauma creates (Kidd, 2004; Kidd & Davidson, 2007).

HIV, Sexually Transmitted Infections (STIs) and Pregnancy

Due to early sexual experiences including sexual abuse, involvement in commercial sexual exploitation, survival sex and engagement in high risk sexual behaviors, such as sex work and having multiple sexual partners, youth experiencing homelessness are at greater risk for HIV, STIs and pregnancy (ICPH, 2017; Rabinovitz, et al., 2010; Tyler, Whitbeck, Hoyt & Yoder, 2000). A national study found that only 29% of youth experiencing homelessness

reported using a condom during every sexual encounter and one in five reported having an STI sometime in their life (ACF, 2016). In addition, literature indicates that lifetime pregnancy rates for females experiencing homelessness is high, with one national study finding that 46% of female youth experiencing homelessness had been pregnant sometime in their life (ACF, 2016).

Due to their housing instability, youth experiencing homelessness are 2 to 10 times more likely to become infected with HIV (National Healthcare for the Homeless Council, 2012), with one study finding 5% of youth experiencing homelessness reporting being HIV positive (Rabinovitz, et al., 2010). In 2015, the Center for Disease Control (CDC) found that youth ages 13-24 accounted for 1 in 5 new HIV infections, with gay and bisexual males, particularly males of color (a population overrepresented amongst youth experiencing homelessness), being the most at risk for HIV infection (CDC, 2015). For young people experiencing homelessness, their housing instability, and the behaviors they are often forced to engage in because of that instability (i.e. survival sex and/or sex work), place them at much higher risk to contract HIV (Logan et al., 2013). In addition, substance use, mental illness and LGBTQ identity, all have been found to be risk factors for HIV infection among youth and all of which are also prominent in youth experiencing homelessness population (Logan et al., 2013).

Victimization:

While victimization, often in the form of physical and sexual abuse, is a causative factor in youth experiencing homelessness, it is also extremely common once youth end up on the streets (ACF, 2016; Gwadz el al., 2007; Petering, 2017; Stewart et al., 2004; Whitbeck et al., 2000). Once on the street, youth experiencing homelessness have a greater likelihood to be physically and/or sexually assaulted, assaulted with a weapon, robbed or otherwise victimized (ACF, 2016, Stewart et al., 2004; Whitbeck et al., 2000). Stewart et al. (2004) found 83% of

youth experiencing homelessness were victims of either a physical or sexual assault while on the street (Stewart et al., 2004). Incidences of victimization on the street lead young people to develop feelings of anxiety and fear for their personal safety, which can adversely impact their emotional wellness (Stewart et al., 2004). Victimization while experiencing homelessness has been connected to young people developing depressive symptoms and PTSD, as well as increased substance use and behavior problems (Stewart et al., 2004; Whitbeck et al., 2000). Furthermore, a young person's previous history of trauma, as well as the trauma caused by experiencing homelessness, greatly heightens a young person's vulnerability to be targeted and victimized, and exacerbates the emotional impact of victimization (Herman, 1992; Stewart et al., 2004).

Commercial Sexual Exploitation and Survival Sex

Many of the drivers of youth homelessness- child abuse and neglect, family conflict, involvement in child welfare or juvenile justice systems and LGBTQ identity- as well as homelessness itself, put youth experiencing homelessness at much greater risk for being commercially sexually exploited (CSE) and/or engaging in survival sex (Cole, Sprang, Lee & Cohen, 2014; Covenant House, 2017; Gragg, Petta, Bernstein, Eisen & Quinn, 2007; National Alliance to End Homelessness, 2011). A 2017 report found that one in five youth experiencing homelessness have been victims of human trafficking, with the clear majority of them being trafficked for sex (Covenant House, 2017). Another study out of Covenant House New York, found that one in four youth experiencing homelessness had been commercially sexually exploited or engaged in survival sex at some point in their lives (Bigelsen, 2013).

CSE refers to any situation in which a young person is forced or coerced by a trafficker/pimp into commercial sex acts resulting in the exchange of items of value, often

money (Cole et al., 2014; National Alliance to End Homelessness, 2011). It should be noted, that many CSE youth are first exploited when they are children and continue to be commercially sexually exploited as young adults (Gragg et al., 2007; Musicaro et al., 2017). Survival sex, sometimes a pathway for a young person to become commercially sexually exploited, is defined as exchanging sex for basic needs such as food, shelter or money (Cole et al, 2014; Walls & Bell, 2011). The Covenant House New York study found that 48% of New York City youth experiencing homelessness had engaged in survival sex due to their lack of shelter (Bigelsen, 2013). A young person's lack of shelter, income or employable skill sets, make them much more likely to engage in survival sex, often engaging in high risk sex (i.e. condom-less sex, multiple sex partners) to get their basic needs met (Bigelsen, 2013; Price et al., 2016).

A young person's past experiences of abuse and trauma, along with an urgency to meet their basic needs and their lack of positive adult connections make them extremely vulnerable to be lured, recruited and forced into CSE or engage in survival sex (Bigelsen, 2013; Cole et al., 2014; Covenant House, 2017; Musicaro et al., 2017; National Alliance to End Homelessness, 2011). Research indicates that 95% of CSE youth have a history of childhood maltreatment, with 49% of youth reporting they were sexually abused as children (Covenant House, 2017). Furthermore, 41% of CSE youth report a history of system-involvement, particularly involvement in child welfare and juvenile justice, experiencing multiple changes in living placements (Covenant House, 2017). In addition, LGBTQ youth, and particularly trans youth experiencing homelessness report extremely high rates of CSE and survival sex (Covenant House, 2017; Dank et al., 2015; Price et al., 2016).

The risk to personal safety, whether a young person experiencing homelessness is commercially sexually exploited or engages in survival sex, is extremely high. Youth engaging

in these behaviors, either by force or necessity, are at risk for physical and sexual victimization, including rape and murder as well as emotional abuse and substance use (Bigelsen, 2013; Gragg et al., 2007; Musicaro et al., 2017; Price et al., 2016; Walls & Bell, 2011). Youth being exploited by a trafficker/pimp, are often the most at risk and report extreme forms of violence and intimidation including kidnapping, gang rapes, torture, starvation, forced drug use and threats to their family and friends (Bigelsen, 2013; Gragg et al., 2007; Musicaro et al., 2017; Reid, 2014). In addition, these young people are targeted by law enforcement and are criminalized for being exploited (Gragg et al., 2007; Price et al., 2016; Yoder et al., 2014). The realities associated with sexual exploitation and survival sex, if experienced either directly or indirectly, are forms of trauma, thus contributing further to the trauma that a young person experiencing homelessness has likely already encountered (Cole et al., 2014; Musicaro et al., 2017).

Criminalization

The realities of youth homelessness, lead youth to engage in various forms of “criminal” behavior, often to meet their basic needs (Ferguson et al., 2011). This “criminal” behavior ranges from substance use, frequently used to cope with homelessness and trauma, to “quality of life crimes” such as jumping a train turnstile, loitering and sleeping on a bench or sidewalk, to “survival crimes”, such as selling drugs, theft, survival sex and/or sex work (ACF, 2016; Dank et al., 2015; Ferguson et al., 2011; Wheeler et al., 2017). Regardless, the engagement in these “criminal” behaviors drastically increases the likelihood that youth experiencing homelessness will become involved in the juvenile and/or criminal justice system (ACF, 2016; Coalition for Juvenile Justice, 2017; Price et al., 2016; Yoder et al., 2014).

A national study of youth experiencing homelessness found that three-fourths of these youth reported some interaction with the police, with 61% reporting they were arrested one time and about 12% reporting they were arrested eight or more times while experiencing homelessness (ACF, 2016). In Hollywood, 69% of youth experiencing homelessness reported they had some experience with the juvenile justice or criminal justice system (Rabinovitz, et al., 2010). In addition, research indicates that the experience of trauma, particularly a history of childhood abuse as well as placement in child welfare (both extremely common experiences among youth experiencing homelessness) are major predictors of criminal justice system involvement for young people (ACF, 2016; Yoder et al., 2014). One study found that youth with a history of physical abuse were twice as likely to be arrested and detained as youth with no abuse history, yet again highlighting the lasting impact of complex trauma on youth experiencing homelessness (Yoder et al., 2014). Furthermore, both youth of color, particularly African American youth, and LGBTQ youth experiencing homelessness, are highly likely to be targeted by law enforcement, criminalized and thus become involved in the juvenile justice and/or criminal justice systems (Dank et al., 2015; Price et al., 2016; Rabinovitz, et al., 2010).

In many respects, the criminalization of young people experiencing homelessness is part of a larger trend across the nation to criminalize homelessness. The criminalization of homelessness is most often seen in local laws that either target those experiencing homelessness directly, or disproportionately impact those experiencing homelessness (National Law Center on Homelessness & Poverty [NLCHP], 2016). Laws that prohibit individuals from sleeping in public places or asking for money or food, more commonly known as “panhandling”, are examples of the criminalization of homelessness (ACF, 2016; Coalition for Juvenile Justice, 2017; NLCHP, 2016). The efforts to criminalize and punish youth experiencing homelessness

can have a lasting impact on young people. This criminalization results in fines, tickets, warrants and possible jail time, all of which can impact a young person's ability to obtain sustainable employment or housing and in some cases, access public benefits, thus trapping them in the cycle of homelessness (Dank et al., 2015; NLCHP, 2016). The criminalization of young people experiencing homelessness also further stigmatizes and isolates already marginalized young people, thus causing them to be more disconnected from society, ultimately placing them at greater risk to experience further trauma.

Oppression and Stigma

For youth of color, immigrant youth and LGBTQ youth experiencing homelessness, their past and current experiences of trauma and the realities of homelessness are often compounded and heightened by the systemic discrimination and oppression they experience due to their marginalized identities (Choi et al., 2015; Price et al., 2016; Rabinovitz, et al., 2010; Wheeler et al., 2017). Systemic discrimination and oppression, particularly racism, classism, xenophobia, homophobia and transphobia, marginalize these young people further, and have a profound impact on their socio-emotional wellbeing, as well as their access to safe housing, employment, and healthcare (Choi et al., 2015; Gattis & Larson, 2017; Price et al., 2016; Wheeler et al., 2017;). Furthermore, research indicates that young people who occupy multiple marginalized identities, particularly as it relates to race, ethnicity, sexual orientation and gender identity, in addition to experiencing homelessness, are much more likely to experience further marginalization and injustice (Gattis & Larson, 2017).

For many youth experiencing homelessness, particularly those who have a marginalized identity, systemic discrimination and oppression is a daily reality. Pervasive racial discrimination on both an individual as well as a structural level deeply impact youth of color,

limiting their opportunities and causing emotional distress related to their subordination and criminalization (Gattis & Larson, 2017; Milburn et al., 2010). Immigrant youth experiencing homelessness, often face hostility within society because of their immigration status (either real or perceived) and must overcome language and cultural barriers while dealing with the challenges of homelessness. In recent years, there has been an influx of undocumented unaccompanied youth from Central America in many regions of the United States. In addition to the barriers that all immigrant youth experience, these young people, have often experienced extreme trauma, both in their home country, as well as on their journey to the United States. Anti-LGBTQ bias and oppression in society not only is one of the reasons so many LGBTQ youth experience homelessness but also plays a role in these young people having higher rates of emotional distress, substance use, victimization, sexual exploitation and criminalization (ACF, 2016; Berg, 2016; Choi et al., 2015; Ray, 2006). Furthermore, LGBTQ youth's challenges in obtaining employment, healthcare and safe housing, are all directly related to anti-LGBTQ bias and oppression within those systems as well (Wheeler et al., 2017). Research indicates that the overrepresentation of Black/African American and/or LGBTQ youth within system care (i.e. child welfare and juvenile justice) is linked to racial and LGBTQ bias and oppression (Berg, 2016; Farrow, Notkin, Derezotes & Miller, 2011).

Amongst the youth experiencing homelessness population, trans youth, and particularly trans youth of color, are exceptionally vulnerable and marginalized (Grant et al., 2011; Price et al., 2016). The National Transgender Discrimination Survey, found that 22% of trans people reported experiencing homelessness in their youth (ages 18-24 years old) (Grant et al., 2011). The study also found that trans people who had experienced homelessness in their youth, were four times as likely to have engaged in survival sex or sex work in order to meet their basic

needs, and 61% of those youth became infected with HIV (Grant, et al., 2011). Further studies have indicated that trans youth experiencing homelessness experience extremely high rates of victimization, sexual exploitation and mental health issues (Choi et al., 2015; Price et al., 2016; Walls & Bell, 2011). The existing literature highlights the multiple intersecting risks that trans youth of color experiencing homelessness experience due to unstable living situations, often exasperated by racism, classism and transphobia rampant throughout society (Price et al., 2016; Wheeler et al., 2017).

In addition, the societal perceptions and judgments around “homelessness” can deeply impact youth (Bender et al., 2007; Kidd & Davidson, 2007; Kidd, 2007; Toolis & Hammack, 2015). Some of the common perceptions of youth experiencing homelessness are that these young people are lazy, they choose to be homeless, they are mentally ill, they are drug addicts or they are “runaways” who do not want to follow rules (Bender et al., 2007; Kidd, 2004; Toolis & Hammack, 2015). These perceptions and judgments placed on youth experiencing homelessness carry a deeply negative connotation, as if the young person is “bad”, “delinquent” or has in some way “failed” (Toolis & Hammack, 2015). The perceptions and judgments placed on youth experiencing homelessness by people and institutions in society have a psychological impact on these youth, often resulting in youth experiencing feelings of stigma, isolation and marginalization (Kidd, 2004; Kidd, 2007; Toolis & Hammack 2015;). In fact, research suggests that social stigma around homelessness, as well as around substance use, mental illness, survival sex and past abuse, all extremely common experiences among youth experiencing homelessness, contribute to young people feeling isolated and hopeless, which has been linked with serious emotional distress, including suicidality among young people experiencing homelessness (Kidd, 2007; Kidd, 2004).

Youth Homelessness and the Social Context:

For case managers working with youth experiencing homelessness, the critical issues presented in the above sections cannot be understood or addressed without placing them into the broader social context of the lives of these young people (Toolis & Hammack, 2015; Wheeler et al., 2017). It is a context in which these young people have experienced extreme and chronic trauma and instability, a context in which people and institutions charged with caring for and supporting them often have done the opposite, a context in which victimization and exploitation are all too common, a context in which poverty and oppression are pervasive and a context in which systems and policies are created to further disconnect, harm, isolate and marginalize them.

While these “critical issues” no doubt impact young people experiencing homelessness individually, and thus require us as case managers to assist them in addressing and overcoming these issues, they are not individual issues or problems. The issues and circumstances that young people experiencing homelessness find themselves facing- educational deficits, mental illness, substance use, victimization, sexual exploitation, criminalization, oppression and social stigma- while on the surface might seem like personality deficits, poor choices and/or clinical pathologies, when placed into the larger context of their life, these issues in large part, are responses to and outcomes of the violent and inhumane environment which these young people are trying to survive in. In providing case management services to young people experiencing homelessness, we must acknowledge and understand the large role that the social environment plays in a young person’s choices, behavior, mental health diagnoses and/or current circumstances (Coates & McKenzie-Mohr, 2010; Goodman et al., 1991; Toolis & Hammack, 2015). In fact, in addition to assisting young people on an individual basis in overcoming these challenges, we must, as case managers, simultaneously, actively, and persistently work to alter

the social environment in which youth experiencing homelessness live. We do this by raising consciousness around issues of injustice, building relationships with others and taking political and social action.

Strengths and Capacity of Youth Experiencing Homelessness

When I think of the young people experiencing homelessness with whom I have worked over the years, what first comes to my mind is their courage, kindness, creativity, openness, independence and humor. I think about the connection or relationship that was developed between myself and the young person. I remember a young person's sense of style, how they communicated and what made them laugh. And I think about their "successes" or "accomplishments", especially those that might not seem like a big deal, like waking up on time or setting a boundary with their partner. In essence, when I think about my work with young people, I immediately think about a young person's strengths, abilities and capacities.

Young people experiencing homelessness possess many positive strengths and abilities such as: independence, self-reliance, problem solving, resourcefulness, positive attitude, humor and a capacity to connect with and care for others (Bender et al., 2007; Kidd & Davidson, 2007; Toolis & Hammack, 2015). Kidd & Davidson (2007) highlight that many young people experiencing homelessness recognize their biggest strength to be their capacity to survive, physically, mentally, emotionally and spirituality, which is no doubt critically important (Bender et al., 2007; Kidd & Davidson, 2007). In addition, like all of us, these young people have abilities or talents unique to them as individuals such as writing, performing, cooking, communicating, drawing, athletics, etc. that allow them to connect with others, provide them unique opportunities and enhance their own self-esteem.

In my work with young people I have found youth's resiliency to be one of their greatest strengths. In my experience, young people's resilience is their willingness and capacity to move through past and current trauma, including all the challenges experiencing homelessness presents, to connect, heal, and transform their lives and the lives of others. Young people's resilience, often begins with their willingness, even after much interpersonal trauma, to connect and develop a positive relationship with others and particularly with their case manager. It is this conceptualization of "resilience" that is at the core of trauma-informed case management services for youth experiencing homelessness presented in this project.

The issues that young people experiencing homelessness often face both before as well as while experiencing homelessness have a profoundly negative impact on their lives, presenting a multitude of complex challenges for these young people to confront. In working with young people experiencing homelessness, particularly in the sphere of case management, it can be easy to focus on a young person's "issues" or "deficits" and what "problem" the young person needs to "overcome" or what goal they need to "accomplish". And while being sensitive and responsive to these realities is important, it is not what drives case management services or our engagement with young people experiencing homelessness. Central to case management with young people experiencing homelessness, is a recognition and embrace of their strengths, abilities, talents and capacities. Ultimately, what drives our work as case managers is the remarkable resiliency of the young people that we work with.

Normative Youth Development

This chapter will focus on normative youth development, often referred to in the literature as “adolescent development”, and will highlight just a few major developmental tasks of adolescence. The purpose of this chapter is to set the stage and highlight youths “normal” or “expected” development. The terms “youth development” and “youth developmental stages” are used interchangeably with “adolescence” and “adolescent development” and are meant to capture and identify young people ages 12-24 years old. The extensive and lasting impact of complex trauma on normative youth development is imperative to keep in mind, as virtually all youth experiencing homelessness have experienced complex trauma and thus have impairments in their normative development. Complex trauma and its effects on normative adolescent development will be discussed in detail in the following chapter, but here, an understanding of normative youth development in all areas of functioning, at all stages of youth development (i.e. early adolescence, middle adolescence and late adolescence) will create an important context for case managers.

Adolescence is a period in which a young person experiences many physical, cognitive and social-emotional changes. These changes have an enormous impact on young people, influencing their future health and social wellbeing (Blaustein & Kinniburgh, 2010; Steinberg, 2014). Blaustein & Kinniburgh (2010) maintain, “Adolescence is a time period marked by rapid changes: cognitive abilities develop, social skills and perspective-taking abilities mature, and physiological development changes rapidly. The adolescent must negotiate all of these changes and integrate them meaningfully” (p. 15). It is the combination of these physical, cognitive and social-emotional changes and how they are “negotiated” and “integrated” by the young person

that make adolescence a challenging, yet dynamic period, not only for the youth themselves, but also for those of us that work with youth.

A unique and important aspect of this project is its goal of creating a model of case management that is sensitive and responsive to the developmental stages of youth. This goal is imperative as much of a youth's biological, cognitive, behavioral, social and emotional responses are directly related to their developmental stage in life. The way youth present in case management- their attitudes, their thought processes, their feelings, their behaviors and their abilities is directly connected with their developmental stage in life (Aviles & Helfrich, 2004; Blaustein & Kinniburgh, 2010, Davis, 2003; Steinberg, 2014). This reality makes understanding and responding to a young person's developmental stage, critically important to both engaging with young people as well as providing them services that are appropriate and meaningful (Aviles & Helfrich, 2004; Blaustein & Kinniburgh, 2010; Davis, 2003).

Throughout this project, references are made to providing services to young people that are sensitive and responsive to their developmental stage in life. Applying a developmental approach, which acknowledges and responds to a youth's developmental stage, allows us, as case managers, to provide them with services and interventions that are more effective. The use of a developmental approach allows us, as case managers, to place the youth's capacities, thoughts and behaviors into context. This can help direct the way we interact with youth as well as help us manage our own thoughts and feelings about a youth's presentation, thoughts and/or behaviors. For example, developmentally, youth are much more likely to engage in high-risk behaviors and/or experimentation (i.e. engagement in high-risk sex), which often poses possible danger to them. If we, as case managers, judge youth for these behaviors or become frustrated when they engage in these "developmentally normative" behaviors, we could lose sight of how

best to interact with these young people or how best to help them address these concerns. Thus, understanding and responding to youth in a manner that honors their developmental stage in life can be imperative for succeeding in the case management process. It should be noted that while it is important not to I problematize normative adolescent development (i.e. experimentation with substances), we must be sensitive not to simply excuse or explain away youth behavior that is not “normal” or appropriate (i.e. become substance dependent) as just normative youth behavior.

The period referred to as “adolescence” is broad and extends for several years. In fact, youth development researchers have broken up “adolescence” into 3 stages of development: early adolescence (11-13 years old), middle adolescence (14-18 years old) and late adolescence (19-21 years old). As stated earlier, for purposes of this project, “youth” is any young person ages 12-24 years old. Within each stage of development, young people often achieve specific developmental milestones in areas such as cognitive, behavioral, social, and emotional functioning. Obviously, youth in the early adolescence stage of development are at the very beginning of their adolescent development, just transitioning out of childhood and will think and act much different than youth in the later stages of adolescence, as they begin to transition into adulthood. Regardless of the youth’s developmental stage, it is important for us, as case managers, to be aware of various stages of normative adolescence development and allow this knowledge, coupled with our knowledge and sensitivity to the lived experiences of youth experiencing homelessness (highlighted in the previous chapter) and their experience of complex trauma (highlighted in-depth in the next chapter) to inform our engagement and services for the youth we work with.

The Adolescent Brain and Normative Development

The development and capacity of the adolescent brain is important to understand when working intimately with young people, as it greatly influences their functioning and behaviors, particularly their cognitive abilities and their capacity to self-regulate (Blakemore & Choudhury, 2006; Steinberg, 2014). Our acknowledgment and understanding of youth's capacities, as it relates to their brain development (i.e. why youth can master/not master certain skills at various periods of their adolescence) helps to inform how we engage with and provide services to youth. It should be noted that for youth, much of the skills and capacities relative to case management, such as understanding the value in case management services, being on time for case management meetings/appointments, and identifying and following through on personal goals are all influenced by a young person's cognitive capabilities (Blaustein & Kinniburgh, 2010). These cognitive capabilities are ultimately influenced by their brain which is growing and changing at an increased rate during adolescence (Blakemore & Choudhury, 2006; Steinberg, 2014).

Dr. Laurence Steinberg (2014), expert in adolescent development states that during adolescence "there are substantial and systematic changes in the brain's anatomy and functioning" (p. 5). In fact, outside of infancy, it is during adolescence that the brain is most susceptible to growth and change through experience, a phenomenon referred to by researchers as "neuroplasticity" (more commonly known as "brain plasticity") (Blakemore & Choudhury, 2006; Steinberg, 2014). Brain plasticity makes adolescence a critical time of development and poses a significant opportunity to positively influence a young person's future (Blakemore & Choudhury, 2006; Steinberg, 2014). In essence it is brain plasticity that allows for a young person's brain to learn and unlearn.

Steinberg (2014) asserts, “if we expose our young people to positive, supportive environments, they will flourish. But if the environments are toxic, they will suffer in powerful and enduring ways” (p. 9). Steinberg’s statement illustrates what many of us working with youth experiencing homelessness already know to be true, that a young person’s environment can have a profound impact on their development and thus their overall wellbeing. As case managers, this opportunity to provide a “positive” and “supportive” environment is exciting, as we can help to promote and shape healthy and meaningful development amongst the young people we work with. For young people who have been exposed to trauma, which negatively impacts their brain development, and thus influences their thoughts and behaviors, the concept of brain plasticity offers hope that these negative and/or toxic influences, can be interrupted, altered, changed and/or replaced (Ford, 2009; Perry, 2005; Steinberg, 2014). For these young people, Steinberg’s encouragement of creating a “positive” and “supportive” environment is all the more important, as it can help to reform a young person’s brain, paving the way for them to grow and flourish.

Key Normative Developmental Tasks

For purposes of this chapter, I will focus on three primary developmental tasks of adolescence- *identity development and independence, cognitive and moral development and self-regulation* (Blaustein & Kinniburgh, 2010; Berzoff, 2011; Erikson, 1963; Piaget, 1977; Steinberg, 2014) and how these tasks might influence the provision of case management services for youth. It cannot go unnoticed that all three-normative youth developmental tasks highlighted here are significantly impacted by the experience of complex trauma and thus will be discussed in detail in a later chapter (Cook et al., 2003; van der Kolk, 2005).

Along with understanding the impact of complex trauma on the developmental tasks presented below, it is also important to recognize how the environment/setting in which young

people experiencing homelessness grow up in (i.e. chaotic/neglectful family environments, foster care/juvenile justice placements, homeless shelters and/or the streets) have on these developmental tasks. For example, a youth who grows up in an institutional setting, such as a group home, not affording them to have “normal” peer interactions and experiences, will then have a compromised sense of self and identity. The dehumanizing experiences of both foster care and juvenile justice, leave many young people unable to achieve a coherent sense of self, as much of their experience within these settings are invalidating, controlled and dehumanizing. In addition, many of these young people become disconnected from their cultural identity, further impacting their sense of self identity. Young people whose settings are chaotic or neglectful often do not have parental figures to role model skills like problem solving or self-regulation, thus these young people do not fully develop these competencies. The examples highlighted above are just a few illustrations of how a young person’s environment/setting also directly influence their achievement of the developmental tasks outlined below.

Identity Development and Independence

Blaustein and Kinniburgh (2010) assert the development of a “coherent sense of identity, a complex understanding of self” is a primary task of adolescence (Blaustein & Kinniburgh, 2010, p. 15). It is during adolescence that young people begin to explore and thus construct their own personal identity- who they are, what they value, etc. (Berzoff, 2011; Erikson, 1963). Within his life cycle stages, Erik Erikson (1963) conceptualized the primary task of adolescence as, “*Identity vs. Role Confusion*”, highlighting the chief developmental task in adolescent development as identity development. Erikson (1963) stated “the adolescent mind is essentially a mind or moratorium, a psychosocial stage between childhood and adulthood, and between the morality learned by the child, and the ethics to be developed by the adult” (p. 245). With the

proper support, this period in-between childhood and adulthood (“adolescence”), allows for the youth to safely and openly explore themselves before solidifying their own personal identity and transitioning into adulthood (Berzoff, 2011; Erikson, 1963). Joan Berzoff (2011) in explaining Erikson’s adolescence stage of psychosocial development, notes that, “the task is to achieve a stable sense of self, which must fit with an image of the individual’s past, present, and future possibilities” (p. 111). This sense of self evolves throughout adolescence, as youth explore who they are- what they like, how they see themselves, what is important to them, etc. In the end their self-exploration helps them develop and solidify their own identity (Blaustein & Kinniburgh, 2010; Berzoff, 2011; Erikson, 1963).

In achieving a “stable sense of self”, youth increasingly assert their own autonomy and independence, often in relation to their parents or caregivers (Blaustein & Kinniburgh, 2010). The assertion of autonomy and independence comes about as youth begin to separate and differentiate themselves from their parents/caregivers (Blaustein & Kinniburgh, 2010). Youth increasingly view themselves as unique individuals, and thus take actions, which can include rebelling against expectations and rules placed upon them and/or exploration, in an effort to elevate and expand their “unique-ness” and individuality. Rosado (2000) observes that, “‘trying on’ different personalities, interests and ways of behaving is a necessary part of the process of putting together an identity” (p. 16). These actions can cause conflict both internally and externally for young people. For example, young people might radically change their appearance, suddenly stop doing an extra-curricular activity they once seemed to enjoy or begin to smoke or use alcohol and drugs, all of which could cause conflict between the young person and their parents/caregivers.

While autonomy and independence are important during adolescence and help to develop a youth's sense of self, so is their connection to their peers (Blaustein & Kinniburgh, 2010; Berzoff, 2011). In fact, peer relations and influence, is a hallmark of adolescence. Throughout adolescence, a youth's peers can have both a positive, as well as a negative influence on them, significantly shaping their daily experiences as well as their personal identity (Berzoff, 2011, Rosado, 2000). Berzoff (2011) maintains, "adolescence provides a time of achieving individual identity through a group identity [i.e. through being with and adopting from their peers]" (p. 111). In many instances, a young person's peers replace the influence that parents/caregivers once had in a young person's life (Berzoff, 2011). During this period, peers often influence each other's appearance, attitudes, likes/dislikes, behaviors and attitudes, which can then influence a young person's sense of self moving forward.

Cognitive and Moral Development

Cognitive development broadly refers to the improved capacity of young people to think, understand and problem solve, all of which progresses throughout adolescence. A hallmark of cognitive development during adolescence is the development of executive functioning skills, which literally changes the way youth think. "Executive functioning" refers to a set of cognitive abilities such as processing and organizing information and experiences, planning, problem solving and critical thinking skills, including the ability to understand cause and effect (Blaustein & Kinniburgh, 2010; Cook et al., 2003). The development of these executive functioning skills play a vital role in the future success and social wellbeing of young people, particularly in their ability to function independently as adults (Blaustein & Kinniburgh, 2010). It should be noted that engagement in case management services (i.e. meeting with the case manager, setting goals, following through on goals, etc.) relies heavily on executive functioning skills, like planning

ahead, critical thinking and understanding cause and effect. The under-development of these skills often impacts a youth's full engagement in case management as well as the comprehension of the purpose of case management services.

Even youth who are capable of enhanced cognitive abilities do not always apply their newly developed/enhanced cognitive abilities in all situations they are presented with (Rosado, 2000). When presented with a situation and/or experience, in addition to utilizing their cognitive abilities, youth also experience conflicting emotions and temptations, such as, risk-taking and sensation-seeking behavior, present-oriented thinking, egocentrism, perceived invulnerability and magical or wishful thinking (Rosado, 2000). Any of these conflicting feelings can and often over-ride a young person's cognitive capabilities in the moment and cause unintended and/or negative consequences (Rosado, 2000; Steinberg, 2014).

As a case manager, I have found "present-oriented thinking", that is a youth's willingness to ignore the future and focus in on the present moment, to have a significant impact on case management. One instance of present-oriented thinking that has shown up in case management multiple times, is with youth who do not have regular access to food. As their case manager, I might suggest these young people apply for SNAP benefits and/or visit a food pantry, both of which aim to address their long-term need to access food. Both of these solutions require the youth to plan ahead and follow through on multiple steps. While it is more sustainable for youth to obtain SNAP benefits or get food from a pantry, I have found that for many young people their "present-oriented thinking" often takes over. Rather than following through on the tasks required to obtain SNAP benefits (i.e. filling out the application, going to the welfare office, etc.) a youth might instead just go to a drop-in space with their friends (peer influences) where they can get a meal on the spot or use what little money they have in the moment, to buy fast food, as

both meet their need for food in the present moment. In my experience, the same youth who opted not to follow through on obtaining SNAP benefits or going to a food pantry, will eventually ask for help again in accessing these services, as they will realize that free meals and/or money for fast food will not always be available to them.

A youth's present-oriented thinking, often leads them not to follow through on the goals they have identified and set for themselves which can be extremely frustrating, especially when we, as case managers, invest time and energy with the youth in helping them accomplish their goals (i.e. obtain regular access to food). However, present-oriented thinking should be expected, as it reflects their developmental stage in life. In expecting "present-oriented thinking", we as case managers must develop patience with the youth and be ready to assist them in following through on their goals when they are ready. In addition, as our relationship strengthens with the youth and they further mature, we, as their case managers can help them process and connect their actions/lack of actions on their goals (i.e. not obtaining SNAP benefits) to various real-life consequences (i.e. being hungry) which then could help facilitate us creating a plan with them to address their needs.

Youth's improved cognitive capacity leads them to become increasingly curious about the world around them and their role in that world. With heightened critical thinking and problem solving skills, youth view and understand concepts, issues and situations differently than when they were children (Blaustein & Kinniburgh, 2010). Their new cognitive abilities, including their keen sense of curiosity, often leads them to question or challenge previously accepted rules, expectations or situations. These "questions" can cause conflict with a youth's parents, caregivers, teachers and/or case managers. For young people, questioning and challenging previously accepted beliefs or practices, help to inform their own values and beliefs,

and thus contributes to their sense of self. As case managers, our encouragement and affirmation of a youth's curiosity and exploration can help to further facilitate their development and strengthen our own connection with the young person.

In their increasingly developed cognitive abilities, youth move beyond the concrete thinking of their childhood, focusing on what is “real and physical”, that is what they can see, touch and experience directly, to being able to appreciate and understand abstract concepts, like justice and equality (Piaget, 1977). Cognitive development theorist, Jean Piaget, called this phase of cognitive development, “formal operational stage” (Piaget, 1977). In the formal operational stage of cognitive development, Piaget asserted that youth begin to think more logically and abstractly (Piaget, 1977). A youth's ability to think abstractly directly influences their ethical and moral development. When thinking more abstractly, youth move away from viewing moral or ethical questions in “black and white”, and they begin to recognize and understand the “grey” areas in life. In addition, youth's advanced cognitive functioning allows them to recognize and step into the perspective and/or experience of others (Blaustein & Kinniburgh, 2010). It is during this period when youth can begin to appreciate the complexity of various moral and ethical issues and understand why the ethical/moral thing to do, might not always give them immediate gratification or directly benefit them.

Self-Regulation

Dr. Lawrence Steinberg's decades of research on adolescence have led him to believe self-regulation is the “central task of adolescence” (Steinberg, 2014). Self-regulation, which is directly connected to a young person's brain development, refers to a young person's ability to control and/or manage his or her thoughts, emotions and actions (Blaustein & Kinniburgh, 2010; Steinberg, 2014). Steinberg (2014) states “self-regulation is probably the single most important

contributor to achievement, mental health, and social success” for young people (Steinberg, 2014, p. 16).

In my experience working with youth, their ability to self-regulate has significant consequences in all aspects of their life. As a case manager, I have seen how a young person’s under-developed capacity to self-regulate has caused them to engage in self-harming behaviors, to experience difficulties in school and employment and create challenges within relationships. Many problematic behaviors associated with youth such as: lack of focus, becoming distracted, hyper-activity, moodiness, emotional outbursts, being argumentative and confrontational, engaging in high-risk behaviors, including self-harming behaviors and experimentation with alcohol and drugs, have all been connected to poor self-regulation (Steinberg, 2014). Furthermore, a youth’s engagement in these behaviors (i.e. substance use) often further perpetuates poor self-regulation, thus it can become a vicious cycle. For example, when a youth becomes angry or annoyed by something, they might not have the capabilities to manage their anger or annoyance in a healthy and appropriate manner, thus the youth might become rude or disrespectful. They might even act out physically (i.e. physically fighting). It cannot go unnoticed that all these behaviors, pose challenges when providing case management services to youth. For instance, a young person’s under-developed ability to self-regulate, can lead them to become easily distracted from following through on their goals or even paying attention during a case management session.

Steinberg (2014) asserts “when our capacity for self-regulation isn’t strong enough to rein in our arousal, problems are more likely to result- problems such as depression, substance abuse, obesity, aggression, and other risky and reckless behaviors” (p. 15). In working with youth, it is helpful to view these “problems” highlighted by Dr. Steinberg through a developmental lens, as

they are often linked to a young person's under-developed ability to self-regulate. In viewing these "problems" in a developmental lens, we are able to address the root cause of these problems (i.e. poor self-regulation) rather than just focusing on what is being presented on the surface (i.e. aggression). It should be noted that many of the problems mentioned above (i.e. substance use, aggression, etc.) might not only be caused by poor self-regulation, but also by under-developed functioning in cognition, such as inability to understand cause and effect or plan for the future.

Due to the significant role that self-regulation plays both in the lived experience of adolescents as well as the influence it has over their future wellbeing, supporting and enhancing a young person's ability to self-regulate is an extremely important task for us as case managers to address with youth (Blaustein & Kinniburgh, 2010; Steinberg, 2014). Steinberg (2014) states "moving an adolescent with poor impulse control into an environment that encourages better self-regulation can make a real difference", underscoring again, the concept of brain plasticity and the great opportunity that exists during adolescence (p. 123). Even youth whose self-regulation is extremely poor, can, in the right environment and with the developmentally appropriate interventions, including case management services, learn to regulate themselves better.

Normative Youth Development and Case Management

For us as case managers, understanding normative adolescent development and applying that understanding in our engagement with young people within the sphere of case management is imperative. For case managers to be effective, and youth to be successful, the case management services we provide to young people experiencing homelessness must be sensitive

to their developmental stage in life. In fact, these services should build off, and capitalize on, this unique period for young people.

Case managers can do this by providing services and learning opportunities to youth that are relevant to them and that connect with their interests. We can offer services that allow youth to engage with their peers, such as psycho-educational groups and community projects and activities. We can validate and encourage the questions and curiosity of young people. We can create safe spaces in which youth can explore who they are and process their own opinions and beliefs. We can provide structure and expectations within our relationship with young people and model emotional management, all in an effort to build up their own self-regulation skills. We can refrain from judging or shaming them for developmentally aligned thoughts and behaviors, such as questioning authority, engaging in high-risk behaviors and their inability to care about and plan for the future. We can be patient and willing to help the same youth, with the same concerns or problems, multiple times over. We can be easily accessible, approachable and ready to work with youth, when they are ready to work with us. And most importantly, we can recognize and honor the surprising opportunity that exists during adolescence, an opportunity that we, as case managers can use to build their skills and capacities, of which ultimately have a significant impact on their life and future wellbeing.

Creating a Secure Base for Youth Experiencing Homelessness

A widespread belief among youth experiencing homelessness advocates is “*ending homelessness is about housing, but ending **youth** homelessness is about relationships*”. This belief places the development of a healthy and positive relationship at the center of our collective work to end youth homelessness. It affirms what many case managers and other youth workers realize in providing services to youth experiencing homelessness everyday: relationships are the vessel for all future healing and progress. A human connection allow for case managers to better understand how to care, support, assist and advocate for young people experiencing homelessness, all which can help these young people to transition off the streets and into safer and more stable housing.

While attachment theory focuses much on the early relationship between a caregiver, often a mother, and her child, the overall concept can be helpful in providing services and support to youth experiencing homelessness. In case manager, attachment theory can inform our practice in two important ways. First, attachment theory can be a means by which to understand the youth we work with and how they relate to us, others and the world (Shilkert & Shilkert, 2011; Slade, 2000). Understanding how attachment behavior has shaped young persons’ lives, specifically how they relate to others, including us as their case managers, is essential in building a genuine and healthy relationship with these young people. Second, we, as case managers can intentionally utilize attachment theory principles as a means of developing a healthy and positive attachment between ourselves and the youth (Bowlby, 1988; Ringel, 2012; Sable, 2008). A healthy attachment establishes and sustains both physical and emotional safety and provides the foundation for case management services for young people experiencing homelessness (Bowlby, 1988; Rapp, 1998).

Attachment Theory

Attachment theory explains the connection or attachment between children and their caregivers and how that attachment is developed and strengthened over time. Attachment theory maintains that the early relationship between child and caregiver is critical to the overall positive development of the child, influencing the way in which the child views self, others and the environment (Bowlby, 1977; Blaustein & Kinniburgh, 2010; Ringel, 2012). John Bowlby, the chief architect of attachment theory, maintains that attachment behavior is the “propensity of human beings to make strong affectional bonds to particular others” (Bowlby, 1977, p. 201). These early “affectional bonds” or attachments, can have a lasting impact on children’s physical and mental wellbeing and set the course for other relationships that children will develop throughout their lifetime (Bowlby, 1988; Sable, 2008).

There are two general types of attachment that a child forms with his or her caregiver: *secure* and *insecure*. Regardless of the type of attachment style that is formed between a child and a caregiver, these early attachment styles develop into, what Bowlby referred to as “internal working models of attachment” (Bowlby, 1969). Shilkret & Shilkret (2011) explain that *internal working models* are “internal templates or schemas of interactions, defining the expectations of infant and young child for what close relationships are like” (p.193). These internal working models of attachment behavior, whether associated to a secure attachment style or an insecure attachment style, then influence the relational interactions and behaviors that individuals develop later in life, including with their case manager (Shilkert & Shilkert, 2011).

The existence of internal working models of attachment underscores Bowlby’s claim that attachment is relevant and present across an individual’s lifespan (Bowlby, 1988). The relevance and presence of attachment style throughout an individual’s life is highlighted further by Mary

Main's work on adult attachment styles. The work of Main et al (1985) expands on the attachment styles, both secure and insecure, developed between a child and his/her caregiver, and identifies and conceptualizes what those attachment styles look like for a particular child when they are an adolescent and an adult (Main, Kaplan & Cassidy, 1985; Shilkert & Shilkert, 2011). For case managers working with youth experiencing homelessness, understanding and then responding to a young person's specific attachment style, particularly the young person's "internal working model of attachment" is critical in developing a relationship with the young person.

Secure attachment occurs when the child and caregiver develop a bond that allows the child to feel safe and secure (Bowlby, 1988). This bond provides the child with a "secure base," referring to the physical and emotional presence of the caregiver, which allows the child to safely explore his or her environment (Bowlby, 1988). Bowlby (1988) asserts that a secure attachment develops when "the individual is confident that his parent (or parent figure) will be available, responsive, and helpful should he encounter adverse or frightening situations" (p. 124). The development of a secure attachment between child and caregiver, helps to facilitate the child's healthy and positive development moving forward, helping the child/youth achieve virtually all their developmental tasks, thus influencing the child's overall wellbeing in adolescence and adulthood (Blaustein & Kinniburgh, 2010; Bowlby, 1988; Shilkert & Shilkert, 2011). Youth with secure attachment histories value the role that attachment and relationships play in their life and are able to emotionally regulate and generally view themselves and others positively (Blaustein & Kinniburgh, 2010; Shilkert & Shilkert, 2011). Children who develop secure attachments early in their life are often able to develop other secure attachments later in life (Bowlby, 1977). The development of other secure attachments later in life is significant, as it continues to assist the

child, now older, in establishing healthy relationships with peers, teachers, partners and co-workers all of which positively influence their wellbeing.

Insecure attachment occurs when a caregiver is unable or unwilling to establish a secure base for the child. Overall, the development of an insecure attachment style can have a profound impact on a child's life, particularly influencing the manner in which they interact and relate to others. Fonagy (2001) maintains that "attachment processes are intimately involved in the development of specific psychological functions or mechanisms that are key in the organization of appropriate behavior. Thus, attachment difficulties may specifically create problems in affect regulation and social cognitive skills" (p. 40). It should be noted that both affect regulation and social cognitive skills are critical competencies for children/youth to master, as they are linked to positive social wellbeing. The negative impact of insecure attachment on affect regulation directly affects the development of a child's ability to regulate their emotions and teaches them to be "frightened by or guarded against emotional experience in general, as all feelings may be perceived as potentially threatening or overwhelming" (Blaustein & Kinniburgh, 2010, p. 50). Furthermore, Bowlby (1977) asserts that "the many forms of emotional distress and personality disturbance, including anxiety, anger, depression and emotional detachment" relate back to "unwilling separation and loss" of the attachment figure (Bowlby, 1977).

Attachment research has identified three different insecure attachments that can develop between children and their caregivers: *avoidant/dismissing attachment*, *ambivalent/preoccupied attachment* and *disorganized/unresolved attachment* (Ainsworth, Blehar, Waters & Wall, 1978; Main & Solomon, 1990).

Avoidant attachment style occurs when a child's caregiver is unresponsive to their needs (Ainsworth et al., 1978). Bowlby (1988) states that "avoidantly attached" children "have no

confidence that when they seek care they will be responded to helpfully but, on the contrary, expect to be rebuffed” by their caregiver (Bowlby, 1988, p. 167). Once older, young adults with avoidant/dismissing attachment styles diminish or “dismiss” the importance of attachments or relationships, which extends onto their relationship with their case manager (Howe, Brandon, Hinings & Schofield, 1999). In explaining the “dismissing” youth Sandra Bloom (2013) states these individuals see themselves as “unloved but self-reliant and other people [as] rejecting and intrusive” (p. 95). Young people with avoidant/dismissing attachment styles have the potential to develop various personality disorders and likely will not recognize the value in building and sustaining an authentic relationship with their case manager, and thus it is difficult to connect with them (Bowlby, 1988; Howe et al., 1999).

Ambivalent attachment develops due to unpredictable and/or inconsistent caregiving between child and caregiver (Ainsworth et al., 1978). An ambivalently attached child does not know if their caregiver will be responsive and available when needed, thus they develop anxiety about exploring their environment (Bowlby, 1988). In describing ambivalent/preoccupied attachment style, Bloom (2013) states the youth/adult sees themselves as “low value, ineffective and dependent” while they view others, as “neglecting, insensitive, unpredictable and unreliable” (p. 95). Young people with a preoccupied pattern of attachment often have low self-esteem and experience anxiety, particularly around whether they are liked and accepted by others, including by their case manager (Howe, et al., 1999). For example, if a case manager is late for and misses a commitment with the young person, it could trigger them to feel unimportant, neglected or rejected. Case managers working with ambivalent/preoccupied young people should be sensitive to the anxiety these young people experience within relationships, while also

identifying and responding to patterns of behavior born out of these anxieties, such as emotional enmeshment and sensitivity to rejection (Howe et al., 1999).

Main and Solomon (1990) identified disorganized attachment style, as one in which the child is fearful of their caregiver, due to the child's experience of abuse and maltreatment, thus developing a "disorganized" attachment style (Hesse & Main, 2000; Main & Solomon, 1990; Shilkert & Shilkert, 2011). Bloom (2013) maintains that young people who have a disorganized/unresolved attachment style view themselves as "confused and bad and other people [as] frightening and unavailable" (p. 95). Sometimes referred to as "fearful" attachment style, young people with disorganized/unresolved attachment styles are highly likely to experience interpersonal and relationship difficulties that are emotionally intense, co-dependent and possibly violent (Fonagy, 2001; Howe et al., 1999). In addition, these young people often experience mental health issues as a result of past trauma, including "cognitive and affective disorientation and confusion, dissociation and lapses in reasoning" (Slade, 2000, p. 1153).

Trauma and Attachment

As indicated previously, complex trauma significantly impacts children/youth's overall development and wellbeing, including their attachment styles, which has a lasting impact on their ability to feel safe and secure (Bloom, 2013; Bowlby, 1977; Cook et al., 2003; Courtois & Ford, 2013). At its core, attachment behavior both facilitates the child's survival as well as the child's ability to thrive and build other secure attachments later in life (Bowlby, 1977; Bowlby, 1988). Bowlby (1977) stated, "by far the most likely function of attachment behavior is protection, mainly from predators," affirming that the primary purpose of attachment behavior is ensuring physical and emotional safety (Bowlby, 1977). Thus, the experience of early childhood trauma, particularly trauma inflicted by a caregiver, such as physical, emotional and sexual abuse

and/or neglect, directly impacts the ability for a child to form a secure attachment with their caregiver (Cook et al., 2003; Courtois & Ford, 2013; Ringel, 2012). If a child's caregiver does not protect the child from a "predator" or is in fact the "predator" then it is nearly impossible for the child to form and/or sustain a secure attachment with their caregiver, as the caregiver is inflicting harm rather than protecting the child from that harm (Bowlby, 1977; Courtois & Ford, 2013; Ringel, 2012). When this happens, the child develops an insecure attachment with the caregiver, often classified as disorganized/unresolved attachment style (Hesse & Main, 2000).

In working with youth experiencing homelessness, disorganized/unresolved attachment is particularly relevant, due to their experience of complex trauma. Sandra Bloom (2013) states that disorganized attachment forms when "their [the child's] attachment figure, who they depend upon for security, is also the source of [their]fear. They [the child] respond to this conflict with mental, emotional, and behavioral disorganization and confusion" (p. 94). Disorganized attachment behavior is often the result of complex trauma, chronic and pervasive trauma inflicted or caused by the child's caregiver, including abuse and neglect and/or the caregiver's inability to develop a healthy attachment with the child due to mental illness or substance use (Fonagy, 2001; Hesse & Main, 2000; Howe et al., 1999). Due to the caregiver's actions, the child develops an attachment that is "incoherent and disorganized, showing a confused mix of avoidance, angry approach responses, behavioral disorientation and inertia" (Howe et al., 1999, p. 29). Disorganized attachment has been found to have an adverse effect on children and youth's wellbeing and has been specifically associated with emotional dysregulation resulting in aggression and relationship violence as well as the development of border-line personality disorder (Fonagy & Bateman, 2008; Fonagy, 2001).

Even if a child and caregiver can establish a secure attachment, the experience of ongoing trauma within the family and community environment, such as community violence or housing instability, can threaten or disrupt healthy attachment behavior (Blaustein & Kinniburgh, 2010; D' Andrea et al., 2012). The most obvious disruption to the development of a healthy attachment between the caregiver and the child is the loss of the caregiver, either physically or emotionally (Bowlby, 1977; Ringel, 2012; Sable, 2008). The physical loss of a caregiver is often due to death or prolonged hospitalization or incarceration of the caregiver. An emotional loss of a caregiver, is when a caregiver is physically present, but is not emotionally present or connected to the child, often due to the caregivers own physical/mental illness and/or extreme economic, social and/or mental stress within the family or community (Blaustein & Kinniburgh, 2010; Howe et al., 1999). Systemic injustices which are pervasive throughout society, including poverty, violence and oppression, often create, facilitate and/or exacerbate the conditions that cause these emotional losses. The loss experienced by the child, either physical or emotional, is traumatic for the child, particularly due to the role that attachment behavior plays early in the life of the child (Howe et al., 1999; Sable, 2008).

The development of an insecure attachment and/or the loss of the primary caregiver can lead the child to experience many broken attachments throughout their childhood, adversely affecting the child/youth's development and wellbeing. These disrupted and broken attachments include: multiple caretakers, multiple and unstable living situations, multiple school placements and multiple therapists, case managers, and teachers. In addition, the child/youth's attachment behavior can be greatly damaged if the adults who are supposed to care for and protect them, such as foster parents or relatives, instead abuse, mistreat, neglect, "look the other way" and/or abandoned them. These experiences, with broken attachments, often are chronic and repetitive

and significantly impact the child/youth's sense of safety and ability and/or willingness to develop safe attachments moving forward (Howe et al., 1999).

For youth experiencing homelessness, past attachment disruptions are very common, with one study finding that 73% of youth experiencing homelessness reported being in at least 3 different foster/kinship homes while growing up, and of those, 23% reported being placed in 11 or more living situations (Rabinovitz, et al., 2010). Each time a child is with a new caretaker or in a new school or has a new therapist, there is an opportunity for an attachment to be formed. Often due to a child/youth's instability, these newly formed attachments, while perhaps less significant than earlier attachments, still can be important to the child/youth and thus when disrupted, broken and/or violated, can be experienced by youth as a loss (Blaustein & Kinniburgh, 2010; Howe et al., 1999). These disrupted and broken attachments, which often begin early in life and continue throughout childhood, are both a cause and consequence of trauma for a young person. Every time a new attachment is formed and then subsequently broken, regardless the reason, further stress is experienced by the child/youth (Howe et al., 1999). The pervasiveness of insecure and broken attachments that many youth experiencing homelessness experience during their childhood and adolescence can be illustrated by Zarah, a young person whom I provided case management services to.

When I first met Zarah, she was only 17 years-old, yet it seemed as though she had a lifetime of broken, unreliable and unhealthy attachments. At the time, Zarah had been living on the street for close to two years with her older "boyfriend", who was sexually exploiting her regularly. Upon first meeting me, Zarah was closed off and provided me with little information about herself or her past, giving me one word answers to basic questions. As time went on, and I

began to very slowly, connect with Zarah, I began to understand the reason she had been so closed off and unwilling to connect and develop an attachment with me.

Zarah was just 9 years-old when she came home to find her mother, whom she loved and described being very close with, dead from a heart attack. Traumatized and heartbroken, Zarah and her older sister were placed into the care of a distant aunt. In the 2 years that Zarah lived with her aunt, Zarah was purposely left out of family outings and activities and was constantly degraded by her aunt. When Zarah was 11 years old, with no warning, her aunt decided she no longer wanted to care for Zarah, so she dropped her off at the child welfare office. Once Zarah was officially in the child welfare system, she experienced continuous instability, leading to countless broken attachments. By the time Zarah ran away from her last foster home when she was 15 years old, she had stayed in 3 emergency shelters, 4 foster homes and 1 long-term group home. Zarah was enrolled in several schools, had 5 different child welfare workers, 4 foster mothers, 3 different therapists, and a new case manager at each shelter and group home.

Unfortunately, Zarah's story is not uncommon amongst young people experiencing homelessness. As a child, while traumatized by the loss of her mother, it is likely that Zarah was open to developing an attachment with her aunt and later to her first child welfare worker, or her new teacher or therapist. However, as the attachments that she developed repeatedly were broken as a result of abuse, victimization, abandonment and the instability of the child welfare system, at some point Zarah began to stop attaching. Zarah and so many other young people's, past experiences of broken and unreliable attachments have taught them not to trust, not to connect, not to attach to others, not to build a relationship. Their experiences of repeated broken attachments, often facilitated by the very systems designed to help them, are a source of great pain and stress for these young people, often compounding their unimaginable trauma and loss.

Thus, for young people like Zarah, it becomes protective for them not to trust and attach to others, in order to lessen the pain, when those attachments are inevitably broken.

Case Managers as a Secure Base

In my work with young people experiencing homelessness the development of a healthy and positive relationship is critical. Youth experiencing homelessness are some of the most vulnerable, marginalized and disconnected individuals in our society. The disconnection that they experience is not just a disconnection from specific individuals because of trauma and loss, but it is a disconnection from families, communities, schools, systems of care and religious communities, all of which leave them with countless broken attachments. In many ways, their disconnection is fueled by systemic forms of disconnection within society such as oppression, poverty and violence. Thus, the connection developed between a case manager and a young person can be a pathway out of their disconnectedness.

Although attachment theory was born out of the relationship that is developed between an infant child and their caregiver, the general concept can be applied to other relationships that individuals might develop when they are older, such as the relationship a young person experiencing homelessness might form with a case manager (Shilkert & Shilkert, 2011). Bowlby himself, believed that attachment principles are relevant to the therapeutic process and could be used to benefit individuals in healing (Bowlby, 1988). The idea that a case manager can serve as a temporary attachment figure for a young person makes the use of attachment theory relevant in providing case management services to youth experiencing homelessness, especially due to the insecure attachment histories virtually all of them have experienced (Bowlby, 1988).

In developing an attachment with a young person, the case manager has the potential to become a “secure base” for that young person, much like a caregiver does for an infant (Bowlby,

1988). This “secure base” like that with an infant, allows the young person to feel emotionally safe with the case manager, allowing for the youth to explore their feelings and experiences without fear of judgement, neglect, victimization or exploitation (Bowlby, 1988). The development of a “secure base” is the first step in establishing safety and trust between a young person and their case manager (Bowlby, 1988; Herman, 1992). The “secure base” that is created, is essential, as it is the foundation for the relationship, and thus all other work between the young person and the case manager. Furthermore, in establishing a secure base with the young person, the case manager is helping the young person to be open to developing relationships with other staff and/or adults in the future, often helping to repair mistrust and damage done by past trauma and broken attachments.

Creating and sustaining a “secure base” or healthy relationship with the young person is the most essential task for a case manager, for it is through relationships that case management progress takes place and healing can occur (Courtois & Ford, 2013; Herman, 1992; Rapp, 1998). Case managers can develop these relationships by employing a strengths-based, youth-centered trauma-informed approach. An approach that meets young people where they are at both physically and emotionally, builds off their strengths and interests and consistently engages them in a safe and non-exploitive manner (Courtois & Ford, 2013; Herman, 1992; Rapp, 1998). This type of youth engagement (detailed in a later chapter) aims to develop and sustain an attachment, thus strengthening the relationship between the case manager and the young person.

Sable (2008) states that “attachment theory presumes that it takes time for the therapist [case manager] to be considered an attachment figure” and thus to establish a secure base (Sable, 2008). In building a relationship with a young person, particularly a young person who has experienced trauma and multiple broken attachments, it is critical to be aware of and sensitive to

the concept of “time”. If “relationships” are what ends youth homelessness, then we, as case managers, must be willing to spend a significant amount of time and energy developing these relationships. We as case managers, must recognize how challenging it might be for youth, like Zarah, with years of broken attachments and loss, to engage with us, to trust us and to connect with us. We must provide the Zarahs we work with, ample time and space for a relationship to develop and recognize that it will not be a linear process.

Along with being sensitive to the time it takes to build an authentic relationship with a young person experiencing homelessness, Sable (2008) asserts that attachment theory “requires that the therapist [case manager] is felt to be familiar, emotionally available and affectively attuned to the client [youth]” (Sable, 2008). Similarly, Bowlby (1988) asserts that a therapist [case manager] should be “reliable, attentive, and sympathetically responsive to his patient’s exploration and, so far as he can, to see and feel the world through his patient’s eyes, namely to be empathic” (Bowlby, 1988 p. 140). Both Sable and Bowlby’s suggestions of being reliable, attentive, emotionally responsive and empathetic are core competencies within any therapeutic engagement and must be applied in the sphere of case management, particularly in creating a secure base for the young person. In building and sustaining a safe and healthy attachment with Zarah it was important for me to be nonjudgmental, open and physically and emotionally available to her when she was ready to engage.

Establishing a healthy relationship with a young person experiencing homelessness can be a challenge particularly because of their pattern of insecure and broken attachments (Bowlby, 1988; Sable, 2008). Bowlby (1988) states that the therapist [case manager] must be “aware that, because of his patient’s adverse experiences in the past, the patient may not believe that the therapist is to be trusted to behave kindly or to understand his [the patient’s] predicament” which

was certainly the case with Zarah, when I first began to work with her (Bowlby, 1988, p. 140). In developing a relationship, many young people begin by pushing away, trying desperately to disrupt the attachment in some way, as means of avoiding the pain of later abandonment of which many have experienced. Young people with a history of insecure attachments often will engage in behaviors, such as being overly attached and dependent or avoiding, disengaging or intentionally acting in a manner that pushes the case manager away. When youth engage in these behaviors, situations are created that make developing a healthy attachment with the youth extremely difficult and emotionally exhausting for the case manager. These challenges make the awareness of and utilization of attachment theory principles all the more relevant for case managers working with homeless young people.

I don't think I fully understood the role that attachment behavior plays in a young person's life until I visited Marion in prison one day. At the time, I had been working with Marion, a bright and fiercely independent 20-year-old, for close to two years. Like many young people experiencing homelessness, Marion had an extensive trauma background, including experiencing extreme physical and emotional abuse, as well as exposure to family and community violence. Marion's experience of physical abuse and extreme neglect at the hands of her parents, beginning when she was very young caused her to develop a disorganized attachment style. The chronic trauma Marion experienced was only exacerbated when she was rejected by her parents due to her gender identity and abandoned by the child welfare system when she turned 18 years-old, leading her to experience several episodes of homelessness. Due to Marion's trauma history, she presented with many symptoms of complex PTSD and was difficult to connect with.

As Marion's case manager, I assisted her with employment and education related issues as well as supported her in the development of basic life skills, particularly emotional regulation. At first, due to Marion's disorganized attachment behavior she was distrustful and fearful of connecting with me, and while she engaged with me to a necessary extent, I could sense her fear in opening up or connecting with me fully. As we continued to meet, Marion became increasingly more comfortable and trusting of me and our relationship began to develop. Many of our case management sessions would start with her talking about her relationship with her boyfriend and the latest fashion and hair style she was experimenting with. Marion would complement me on my latest hairstyle, which was always the same, as I am balding, and we would laugh.

When I saw Marion that day in prison, on the other side of the glass, in a blue prison jump suit, my heart broke. I smiled as she sat down across from me. I was there simply to check in with her, to provide her with support, support that I would provide to any of youth with whom I worked. We talked about her hair, how she was getting along with the other inmates and the food. We joked about both thinking pork was nasty.

Then, rather abruptly, Marion told me that the police probably had her keys and explained I could probably get the keys from the police that arrested her. Marion was referring to the keys to her apartment (Marion was staying in an apartment within a youth housing program). I reassured her we could get her new keys and not to worry and then asked her about the rest of her personal property. We continued to chat for a while more and as I was getting ready to leave, Marion began to cry, which she never had done before. Marion thanked me for coming to see her. I of course smiled and said "no problem" and assured her I would be at her court date later that week.

After I left, I kept thinking about Marion wanting to give me back her keys. Why? What was that all about? In visiting Marion, her keys were literally the last thing on my mind. And then it hit me, Marion did not think I was there to check in with her and provide her with support. She did not think that I was there because we had developed an attachment. No, Marion thought I had come to get her keys and exit her from the apartment she was staying in. Marion thought I was there to take away her housing.

It was in that moment that I began to understand the deep and lasting influence of insecure attachment behavior and more specifically disorganized attachment behavior. For as long as Marion could remember, people like her parents, and organizations like the one I worked for, had failed to show-up for her, care for her, protect her, love her. Marion's attachment history was so damaged from years of trauma and loss that it was almost impossible for her to imagine that someone like me, her case manager, would come to visit her in prison for any other reason, but to get her keys and exit her from housing. To reject and abandon her once more.

I was not aware of it then, but showing up for Marion that day with the intention of expressing my genuine care and support for her was a powerful intervention. It allowed her to experience a secure base and an attachment that was unconditional. It showed Marion that the attachment we were developing together was authentic and that it was not going to be easily broken. Ultimately, our relationship was strengthened by my visit and had a positive impact on our work together moving forward. In recalling our visit many months later, Marion said "you know that was dope [referring to me visiting her]. No one has ever done something like that for me before".

The relationship that Marion and I developed overtime highlights the importance of building and sustaining a safe and positive relationship with a young person experiencing

homelessness. It highlights that even after all the trauma, loss and broken attachments, young people like Marion, still have the courage and desire to open themselves up and build a relationship with their case manager. Young people's willingness to connect and build a relationship speaks to their own capacity and resilience. It highlights the strength and hope they possess within themselves.

Our job as case managers is to develop and sustain a relationship that is safe and positive, a relationship that is non-exploitative and non-judgmental, a relationship in which the young person feels supported and cared for, a relationship that is unconditional and can bare the push back and/or "acting out" from a young person, a relationship in which they are respected and affirmed for who they are in that moment and finally, a relationship in which healing can occur and transformation can begin. In essence, our job as case managers is to create a secure base.

By developing a secure attachment with young people, case managers are ultimately strengthening the therapeutic alliance between themselves and these young people, which is essential when providing case management services (McManus & Thompson, 2008; Rapp, 1998). The development of a healthy attachment between a young person and their case manager results in the young person feeling safe, thus helping to facilitate their emotional development and possible healing (Bowlby, 1988; Herman 1992). A youth can then focus on other more concrete needs such as housing stability, employment, education, life skills development and emotional wellbeing, all essential case management goals for youth experiencing homelessness. The case management work I did with Marion: connecting her to resources, helping her enroll in school, developing her resume and job interview skills, providing her tools to manage her time and regulate her emotions, and enhancing her ability to develop

healthy relationships with others, were all born out of the relationship we had developed together.

At its core, our work with youth experiencing homelessness is about restoring and enhancing the dignity of these remarkable young people. It is about “showing up”, physically and emotionally, and supporting youth like Marion. There is no more basic way of doing this than by forging a human connection. For stigmatized and marginalized young people, who have experienced complex trauma and countless broken attachments, the very development of a healthy and safe relationship with a case manager can be transformative. Through a relationship with the case manager, the young person can begin to heal and grow. In such a relationship, their humanity is recognized, honored, celebrated and protected. The development of a relationship that is unconditional and safe honors the inherent dignity of the young person. It shows the young person they are worthy of connection. They are worthy of a secure base.

Complex Trauma and Youth Experiencing Homelessness

As indicated earlier, trauma is both a cause and consequence of youth homelessness. Virtually every young person experiencing homelessness with whom I have worked is a survivor of trauma and in most cases, these young people have experienced multiple, prolonged, and concurrent traumas. The unimaginable trauma that young people experience both before and while experiencing homelessness, including the experience of homelessness itself, causes much pain and disconnection and has a significant impact on the health and wellbeing of these remarkable young people.

The Substance Abuse Mental Health Services Administration (SAMHSA), states “individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional or spiritual well-being” (SAMHSA, 2014, p. 7). In her landmark book *Trauma and Recovery*, Dr. Judith Herman states, “Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life,” (p. 33). Herman (1992) goes on to explain why trauma has such an overwhelming impact stating, “Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning” (p. 33). Herman reinforces what many of us already know in working with young people experiencing homelessness: trauma violates the very core of who they are. It violates their sense of self, their connection with others and how they understand and interact with the world. It is a violation that for many of us, is difficult to truly understand or feel but a violation that we cannot ignore or discount when working with young people experiencing homelessness. The impact of trauma on the lives of young people we work with requires us to utilize a trauma-

informed practice that recognizes, understands, and responds to the violations/traumas directed at a young person's humanity (Bender et al., 2014; Bloom, 2013; Courtois & Ford, 2013; Herman, 1992; Musicaro et al., 2017).

To illustrate the “extraordinary” impact that trauma has on youth experiencing homelessness, I will share the story of Pedro, a young person I provided case management services to. For those of us working with young people experiencing homelessness, we have all worked with youth like Pedro. His story reminds us of the deep and lasting impact that trauma has on the young people we work with every day.

Pedro grew up in one of the most violent and poverty stricken communities in the country. As a young child, physical and verbal abuse were pervasive in his tiny home and gangs and drugs ruled the streets. Pedro would often go to sleep hungry and scared, listening to periodic gun fire and the occasional police helicopters overhead searching for someone in the neighborhood. Desperate to please his abusive and meth addicted father, Pedro tried to make himself useful, doing chores and tasks around the house. Although he was a child himself, he took care of his younger siblings in the hopes he would avoid the abuse, that inevitability would come his way. When Pedro was 8 years old, he woke up to find his mother had abandoned him. Pedro learned she, also addicted to drugs, had run off with her latest boyfriend, leaving Pedro and his siblings in the care of their cruel father.

Throughout his youth, Pedro was terrorized by those who were supposed to care for him, in a place that was supposed to be safe. As a teenager, with no one to protect him, Pedro was subjected to continued physical and verbal abuse from not just his father, but his older brother and cousin as well. Then, when Pedro was 13 years old, his older cousin began to sexually abuse him, threatening Pedro if he told anyone.

Along with the abuse and victimization that Pedro experienced at the hands of his father and older cousin, there was a constant stream of strangers through the house, most of whom were there to buy drugs and get high. Outside the home, Pedro witnessed extreme violence daily, including people getting stabbed and shot. At school, he was often teased and bullied. When the family learned, through a teacher that Pedro confided in, that Pedro was gay, his father threatened to kill him and his family viciously teased him. It was shortly after his teacher's betrayal and the violent reactions from his family, that Pedro, almost 17 years old, ran-away from home.

After leaving home, Pedro found his way to a drop-in center for youth and after speaking with Pedro, the staff decided to contact child welfare. Pedro was extremely relieved that child welfare was contacted, as he thought finally he would be rescued from his nightmare of violence and trauma at home. Child welfare temporarily placed Pedro into a youth shelter while they investigated Pedro's situation. Unlike many traumatized youth, Pedro trusted the child welfare worker and shared with her some of the trauma that he had experienced growing up, although much of it was hard for him to remember and/or communicate.

While in the shelter Pedro began to feel safe and cared for and connected with several of the staff. However, after several months, when the investigation was concluded, the child welfare worker, whom Pedro had trusted to protect him from his father, recommended "family reunification" (likely because of his father's ability to convince the child welfare worker Pedro had embellished his story of abuse and neglect, along with the fact that Pedro was almost 18 years old and opening up a child welfare case just before he was 18 was extremely difficult). Thus, it was determined that Pedro would be placed back in the care of his father. Upon learning the news, Pedro ran away from the youth shelter, vowing never to go back home.

Pedro's experience of multiple, concurrent and chronic trauma, represents just one, partial story of surviving the unimaginable. I say "partial" because no matter how strong of a relationship we develop with a young person, we as case managers, will never fully know everything that a young person has endured. However, I share Pedro's story and his experience of complex trauma, as a means for us to begin to acknowledge, understand, feel and connect with him and the countless other complex trauma survivors we work with daily.

What is Complex Trauma?

The concept of "complex trauma" was born out of the realization that chronic and prolonged trauma, beginning early in life and continuing throughout childhood and adolescence looks much different in presentation and impact than a single episode of trauma experienced by an adult (Cook, Blaustein, Spinazzola & van der Kolk, 2003; Courtois & Ford, 2013; van der Kolk, 2005). Because of this unique experience of trauma, childhood trauma workers and researchers developed the concept of "complex trauma". The experience of complex trauma has a profound impact on a young person's physical, emotional, cognitive, behavioral and relational development and functioning. It is often the reason a youth struggles to regulate their emotions and behaviors, engages in high-risk behaviors, lacks basic life skills and personal competencies and struggles in education and employment (Cook et al., 2003; Courtois & Ford, 2013; D'Andrea et al., 2012). In short, virtually all the critical issues impacting youth experiencing homelessness (i.e. substance use, mental and emotional distress, employment and education difficulties, etc.) are in some way linked to a young person's experience of complex trauma and the impairments it causes (Coates & McKenzie-Mohr, 2010; Cook et al., 2003; Courtois & Ford, 2013; Musicaro et al., 2017). This reality makes understanding complex trauma and its impact on young people experiencing homelessness essential for case managers.

Cook et al. (2003) states complex trauma “refers to children’s experience of multiple traumatic events that occur within the caregiving system- the social environment that is supposed to be the source of safety and stability in a child’s life” (p. 5). These experiences of multiple, concurrent and prolonged traumas include: physical, emotional and sexual abuse, neglect, domestic violence, victimization and exploitation, parental substance use, parental mental illness and parental incarceration, and poverty and housing instability (Cook et al., 2003; Courtois & Ford, 2013; Musicaro et al., 2017). Experiences of interpersonal trauma- physical, verbal and sexual victimization perpetrated by family members or other important adult figures- can be especially damaging for young people (Ford, 2009). Incidences of interpersonal trauma are often extremely personal and targeted and are not isolated incidents but happen to a young person over a prolonged period of time, escalating in brutality (Courtois & Ford, 2013; van der Kolk, 2005). For Pedro, the interpersonal trauma, the victimization at the hands of his father and older cousin, and the sense of betrayal that accompanied that victimization (another form of trauma) impacted him significantly and layered on top of and exasperated the other trauma he experienced.

For purposes of this project the concept of complex trauma will extend not only to trauma experienced in a young person’s individual caregiving environment but also to the multiple and concurrent traumas a young person faces outside this immediate caregiving environment. Traumas such as bullying, community violence, police brutality, attachment disruptions, multiple/unstable living arrangements, homelessness, hunger, victimization, sexual exploitation, subjugation, oppression, marginalization and criminalization, all violate a young person’s sense of safety and can be especially damaging when experienced concurrently and sustained over a period of time during their childhood and adolescence (Courtois & Ford, 2013; Herman 1992; Musicaro et al., 2017). The project’s expanded conceptualization of complex trauma as it relates

to youth experiencing homelessness seeks to not only honor their lived experiences but also to broaden the concept of “caregiving system” that Cook et al. (2003) refer, to include institutions and systems charged with caring for and protecting young people. Child welfare agencies, juvenile justice departments, public schools, medical clinics, places of worship, and society as a whole all have their role in helping shape a child’s healthy development and ensure their safety.

The National Childhood Traumatic Stress Network (NCTSN), comprised of experts in the field of childhood trauma, has played a significant role in the identification, treatment, advocacy and research of complex trauma. In its research and practice, NCTSN identified seven specific areas of impairment in children and youth, as a result of experiencing complex trauma: *attachment, biology, affect regulation, disassociation, behavioral regulation, cognition and self-concept* (Cook, et al., 2003; van der Kolk, 2005). In conjunction with and addition to the impact that these impairments have on a young person, research indicates that the experience of complex trauma is linked with adverse health effects, impacting a young person’s physical and mental health well into the future (Felitti et al., 1998). As it relates to mental health, complexly traumatized children and youth are found to have increased incidences of depression, anxiety, PTSD symptoms, and personality disorders as well as engagement in high risk behaviors such as substance use, self-harming and high risk sexual behaviors (Bender et al., 2014; Courtois & Ford, 2013; D’Andrea et al., 2012; Felitti et al., 1998). It is the combination of the emotional distress of trauma and the developmental and functioning impairments resulting from the trauma, that make complex trauma such a significant barrier for youth experiencing homelessness.

Complex Trauma: Areas of Impairment Most Relevant to Case Management with Youth Experiencing Homelessness

As indicated earlier, NCTSN maintains that complex trauma disrupts the healthy normative development of children and youth and causes impairments in several critical areas of functioning, ultimately impacting a young person's overall social wellbeing (Cook et al., 2003; van der Kolk, 2005). D'Andrea et al. (2012) explains that complex trauma places "children and adolescents at risk of chronic and severe coexisting problems with emotion regulation, impulse control, attention and cognition, dissociation, interpersonal relationships, and attributions" (p. 188). It is imperative for case managers to understand the impairments in development and functioning caused by complex trauma, as these impairments often contribute in youth experiencing homelessness in the first place.

Furthermore, complex trauma has been linked to negative physical and mental health issues, involvement in the juvenile and criminal justice system, engagement in high risk behaviors, including substance use and experience of further victimization and exploitation (Cook et al., 2003; Felitti et al., 1998; Musicaro et al., 2017). Understanding the physical, emotional, behavioral, relational and cognitive impact of complex trauma, helps case managers to better understand, engage and assist youth within case management and is at the core of a trauma-informed case management practice. It should be noted that many of the impairments caused by complex trauma highlighted below connect with and often reinforce one another (i.e. the development of an insecure attachment as a result of complex trauma often paves the way for difficulties in affect regulation, self-concept, etc.).

Attachment

As presented in depth in the previous chapter the healthy attachment or relationship between young children and their caregivers is critically important for the children's emotional and social development (Bowlby, 1977; Bowlby, 1988; Cook et al., 2003). For children who

experience abuse, neglect and victimization at the hands of their caregiver, a healthy and safe attachment is nearly impossible. For complexly traumatized children and youth, the absence of a healthy or “secure” attachment robs them of feeling safe and supported by their caregivers and subsequently other individuals in their life later (Bloom, 2013; Bowlby, 1977). In addition, insecure attachments during childhood, adversely impact a children/youth’s ability to tolerate and manage stressful situations, regulate their emotions, and trust and connect with others, all problems that youth experiencing homelessness often exhibit and all of which adversely impact their life moving forward (Cook et al., 2003; Courtois & Ford, 2013).

Brain Development

Complex trauma significantly alters a child’s brain development, which in turn is linked to the impairments in a young person’s affect and behavior regulation as well as cognition and self-concept (Cook et al., 2003; Steinberg, 2014; van der Kolk, 2014). In fact, the experience of complex trauma quite literally reshapes a young person’s brain, setting the course for how a young person understands and experiences the world moving forward (Bloom, 2013; van der Kolk, 2014). Dr. Bessel van der Kolk, a renowned traumatic studies expert states “Trauma results in a fundamental reorganization of the way mind and brain manage perceptions” (van der Kolk, 2014, p. 21). The two areas of the brain that are most influenced by complex trauma are, the frontal lobe and the brainstem. The frontal lobe -*the learning brain*- is responsible for executive functioning skills such as, critical thinking, planning and impulse and behavior control, while the brainstem- *the survival brain*- is responsible for a young person’s basic survival functions, including processing and responding to threats and danger (Ford, 2009; Perry, 2005; Steinberg, 2014; van der Kolk, 2014).

Growing up in the habitual state of fear, unpredictability, and stress, the hallmark of complex trauma, causes young people to be in a chronic state of hyperarousal, leading them to operate from their survival brain, always ready to respond to real or perceived danger (Bloom, 2013; Ford, 2009; Perry, 2005; van der Kolk, 2005). In explaining this state of hyperarousal, Bloom (2013) asserts “essentially, the baseline level of arousal for the person has changed [due to complex trauma] and they cannot control their own responses to stimuli [real or perceived danger]” (p. 42). This inability to control their own responses to fear and stress, real or perceived, causes young people’s entire bodies- their physiology, emotions and behaviors to become dysregulated (Bloom, 2013). It should be noted that for complexly traumatized youth, whose survival brain is in constant use, a survival response can be activated not just by an actual threat (i.e. abuse), causing fear or stress to the young person, but also by a perceived threat or reminder of past trauma, often referred to as a “trigger” (Blaustein & Kinniburgh, 2010; Courtois & Ford, 2013). van der Kolk (2014) asserts that “we could only conclude that for abused children, the whole world is filled with triggers,” highlighting the pervasive state of arousal and vigilance a complexly traumatized young person develops and inevitably presents to us, due to past traumatic experiences (van der Kolk, 2014).

When a young person’s survival brain is activated either due to a real threat or a trigger, there are three survival responses that could be employed: *fight*, *flight* and/or *freeze* (Blaustein & Kinniburgh, 2010; Bloom, 2013; Cook et al., 2003; Perry, 2005). These survival responses are automatic and unconscious (Ford, 2009). In the fight stress response, a young person experiences physical activation, within their body, which leads them to engage in physically aggressive actions or behaviors (Blaustein & Kinniburgh, 2010). In the flight stress response, a young person removes her/himself from the situation, often avoiding or running away from the

cause of the stress (Blaustein & Kinniburgh, 2010). The freeze stress response is a when a young person constricts their movement, behavior and/or emotions, often resulting in them being overly compliant during times of intense fear or stress (Blaustein & Kinniburgh, 2010).

Courtois and Ford (2013) explain that “survival reactions [responses] become ingrained, leaving their imprint on the individual’s physiological and personality development. Survival can come to define a person’s entire sense of self and his or her ability to self-regulate and to relate well and intimately with others” (p. 4). Courtois and Ford remind us that many of the “problematic” or maladaptive behaviors or thought processes a young person engages in, are “ingrained” and “imprinted” on a young person’s brain and are not necessarily being done consciously (Courtois & Ford, 2013). The feelings of fear and helplessness experienced due to the threat or perceived threat and the behaviors a young person exhibits as a result of the stress response employed to manage a threat or perceived threat, often leads the young person to be misunderstood and/or misinterpreted by others (Perry, 2005). These misunderstandings can have significant implications for young people, such as being ignored and forgotten about, misdiagnosed and overmedicated, suspended from school, kicked out of shelters or criminally detained. Perry (2005) maintains “it’s an unfortunate reality that the very adaptive responses [the behaviors and thought processes elicited by a young person’s survival responses] that help the child survive and cope in a chaotic and unpredictable environment puts the child at a disadvantage when outside that context” (p. 2).

The disadvantage Perry (2005) refers to is underscored by a young person I once worked with who was almost exited from her housing program because she never attended the program’s weekly community dinners (which was a requirement of the housing program). The housing program staff reported that the youth would either disappear right before the community dinner

or refuse to attend the dinner. When I asked the young person why she was not attending the dinner, she shared with me that she did not feel comfortable eating with everyone in the program. She then shared that growing up her family never included her in any family meals, activities or outings and that being included now (by people who she did not even know) made her feel “some-type-a-way” (a phrase youth say to mean many different things, in this case it was meant to express her being triggered). In speaking with her it was clear that for this young person, participating in a community dinner was a trigger, as it reminded her of all the times her family rejected her. To manage the fear and stress that she felt when a situation arose that was similar (i.e. community dinners), her “flight” survival response was enacted, thus she avoided the dinner. Unfortunately, the staff did not understand or seem to care why the young person was avoiding the community dinners nor did they recognize her avoidance of community dinners as a learned survival response, a way to cope with her past trauma and the feelings it brought up for her. Instead of recognizing and responding to the young person’s behavior as a reaction caused by the complex trauma she experienced, the staff interpreted her avoidance as resistance and disobedience of the program, behavior that almost got her exited from housing.

As case managers working with young people experiencing homelessness the concept of “brain plasticity” is very important, for it maintains that the brain, which is linked with many of the impairments that complex trauma causes, can reorganize itself to healthy and normative functioning (Ford, 2009; Perry, 2005; Steinberg, 2014). Trauma-informed case management services can be a way in which a young person’s brain can begin to be re-formed. Part of trauma-informed practice (discussed in detail in a later chapter) is empowering young people with information about complex trauma and the various ways it can impact youth broadly, as well as how it might have specifically impacted them as an individual. Within case

management, we can assist young people in identifying their triggers and exploring the reason for these triggers as well as develop skills and capacities that might help them move beyond their traditional trauma responses/coping methods. In doing this a young person's brain will be reformatted and reorganized, thus positively impacting functioning and wellbeing.

Affect and Behavioral Regulation

For complexly traumatized youth impairments in affect regulation, which is the ability to appropriately identify, label, express and/or regulate their emotional state, is significantly compromised (Blaustein & Kinniburgh, 2010; Cook et al., 2003; Steinberg, 2014). Young people's inability to regulate their own emotions in a safe, healthy and positive manner, both internally as well as externally, can lead young people to engage in maladaptive, unhealthy and often dangerous expressions of these emotions (Cook et al., 2003; Courtois & Ford, 2013; Steinberg, 2014). Cook et al. (2003) asserts that young people's inability to effectively regulate their internal emotional state can drive them to engage in "chronic numbing of emotional experiences, avoidance of affectively laded situations, including positive experiences, and/or the use of behavioral strategies (i.e. substance use)" (p. 12). In addition, as a young person grows older, emotional dysregulation can lead to various mood disorders, including major depression (Cook et al., 2003). As case managers working with youth experiencing homelessness, assisting young people in improving their emotional regulation, through building their personal skills and capacities to identify and express their emotions, is critical (Blaustein & Kinniburgh, 2010; Steinberg, 2014). Furthermore, we as case managers can, ourselves, role model in real time for young people, healthy and positive forms of emotional regulation, particularly in times of stress, by responding to stress in a calm, positive and productive manner.

With regards to behavior regulation, Cook et al. (2003) explains that a complexly traumatized young person often exhibits either “under-controlled” or “over-controlled” behavior, both of which can have negative impacts on their ability to function positively in many areas of life including within schools and housing programs (Cook et al., 2003). Under-controlled behavior or impulsive behavior happens when a young person is unable to control her/his impulses, thus engaging in more reactionary behaviors (i.e. aggression toward others, oppositional behavior and self-destructive behaviors), and is strongly linked with a young person’s impairments in executive functioning (Cook et al., 2003). Over-controlled behavior in youth refers to the development of extremely controlled and inflexible behaviors and ways of engaging resulting in difficulty understanding and following rules, extreme compliance, eating disorders and self-harming behaviors (Cook et al., 2003). Recognizing and understanding how dysregulated behaviors such as a young person cussing someone out on the train, are connected to a young person’s impairment in behavioral regulation, a consequence of complex trauma can be very helpful in understanding the “why” of a young person’s behavior. Along with affect regulation, assisting youth in developing and improving their capacity to regulate and manage their behavioral responses no doubt has a positive influence on a young person’s overall functioning and wellbeing and is a worthwhile task for us as case managers to take on.

Cognition

A young person’s deficit in cognitive functioning is strongly linked with the impairments in brain development caused by complex trauma (Cook et al., 2003; Courtois & Ford, 2013). van der Kolk (2014) maintains that trauma “changes not only how we think and what we think about, but also our very capacity to think” (p. 21). Because much of complexly traumatized youth’s physical, emotional and cognitive energy is focused on survival, the area of their brain

responsible for higher level functioning skills such as information processing and critical thinking, is neglected, and thus becomes severely under-developed (Blaustein & Kinniburgh, 2010; Cook et al., 2003; van der Kolk, 2014). This neglect and under-development ultimately leads to cognitive deficits in: overall IQ, language development and executive functioning, all of which pose significant challenges for young people's development and daily functioning, effecting basic life skills, competencies and academic performance (Cook et al., 2003). In relation to a young people's academic performance, impairments in cognition can pose challenges in learning and knowledge attainment, the ability to positively engage with their peers and teachers, as well as, the capacity to demonstrate appropriate behavior, all of which are contributing factors to high drop-out rates (Blaustein & Kinniburgh, 2010; Cook et al., 2003).

A young person's deficits in executive functioning is one of the most significant cognitive impairments related to the experience of complex trauma as these skills are essential for the young person in effectively navigating daily life. Executive functioning refers to a set of cognitive processes and abilities that allow for a young person to function independently such as: processing and organizing information and experiences, planning, problem solving and critical thinking, including the ability to understand cause and effect (Blaustein & Kinniburgh, 2010; Cook et al., 2003). Compromised executive functioning can lead to a number of problems for a young person from saying or doing something without realizing the consequences, to being late for work or school because of the failure to plan and manage time effectively, and searching for and expecting immediate gratification. For insistence, what might be interpreted as a young person's "resistance" to accomplishing a case management task or goal, in fact may not be resistance at all, but rather deficits in executive functioning, such as a young person's inability to process information given to them or understand cause and effect.

Due to impairments in cognition, young people I have worked with often lack basic competencies I would expect them to have mastered, as per normative development, such as how to tell time, clean up after themselves or follow directions from a map. Often what I have found is that young people lack these basic competencies because they were never taught them in the first place, often a consequence of a chaotic and unstable childhood or if they were taught them, they were unable to process the information to master the competency due to their cognitive impairments caused by complex trauma. Furthermore, Blaustein and Kinniburgh (2010) remind us that for complexly traumatized youth, deficits in executive functioning, including not having competencies and skills to effectively manage and cope with everyday life, “layer on top of, the child’s [youth’s] [dysregulated] behaviors and emotions”, ultimately forcing these young people to “rely on alternative adaptations- or a range of behaviors and strategies designed to help the child [youth] to cope with internal and external experiences” (Blaustein & Kinniburgh, 2010, p. 30). As case managers, we must be aware that the alternative adaptations young people develop such as: emotional numbing, social withdraw, need for control, engagement in unhealthy relationships, high risk sexual behaviors, self-harm, substance use and aggressive behaviors are symptoms of not only experiencing complex trauma but of the cognitive impairments that young people acquire due to their experience of complex trauma (Blaustein & Kinniburgh, 2010). This realization can help case managers can better understand and support youth experiencing homelessness.

Self-Concept

For young people who have spent much of their life just trying to survive, often by reacting to and/or coping with various traumatic situations, their identity and sense of self is severely compromised thus they have impairments in identity development and self-concept

(Blaustein & Kinniburgh, 2010; Cook et al., 2003; Courtois & Ford, 2013; van der Kolk, 2014).

Because these youth lack a sense of safety, it is challenging for them to explore who they are and be exposed to new and safe opportunities that help them in developing a positive sense of self (Blaustein & Kinniburgh, 2010; Courtois & Ford, 2013). These young people struggle to identify their likes and dislikes, their personal strengths and their passions. They often can grow up with few positive adult role models, which limits what they see as possible for themselves in the future.

In working with young people, I have often observed how their compromised sense of self impedes much of the goal setting and future planning that happens within case management. For example, I have known many young people who struggle to determine what kind of job they would like to apply for or what field of study/career path they would like to pursue, thus they often will disengage or avoid these discussions. Their disengagement or avoidance, is often interpreted by case managers, and by society as a lack of motivation, laziness and/or oppositional behavior on the part of the youth. However, I have found that oftentimes, youth struggle with these decisions and thus disengage or avoid them, because they lack exposure and insight as to what they like, what they are good at and/or what it is that they are passionate about. This lack of exposure and insight into their basic interests, strengths and capacities is almost certainly related to their deficits in self-concept. For youth experiencing homelessness, working with a trusted case manager might be the first time a young person has experienced physical and emotional safety in their life and thus finally can explore and experiment without fear of being judged, degraded, harmed, or exploited.

In addition, Blaustein and Kinniburgh (2010) maintain that “children who are routinely rejected, harmed, or ignored [thus developing a disorganized attachment behavior] internalize an

understanding of self as unlovable, unworthy, helpless, or damaged” (p. 191). As these children grow older, this internalization causes them to develop a negative sense of self, which in turn leads to poor self-esteem, as well as, feelings of shame and guilt (Cook et al., 2003; D’Andrea et al., 2012). A young person’s poor self-esteem ultimately influences their confidence to try new situations, stick up for themselves, and seek out help, ultimately impacting their success in school, work and various social situations (Blaustein & Kinniburgh, 2010; D’Andrea et al., 2012). In addition, young people’s lack of confidence and feelings of shame and guilt can drive them to engage in high risk behaviors such as, self-harming behavior, substance use and high risk sex, often placing these young people at further risk for negative health and wellbeing outcomes (Cook et al., 2003; D’Andrea et al., 2012).

Health Effects of Complex Trauma: Adverse Childhood Experiences

In examining the role that complex trauma has on a young person’s future, it is important to take note of the landmark, Adverse Childhood Experience (ACE) study. The ACE study documented the impact that “adverse childhood experiences” (that is the experience of multiple victimizations and/or trauma a person experiences during childhood), has on the health and wellbeing of children as they grow older. The ACE study, one of the most comprehensive studies looking at the impact of childhood victimization and trauma, focused on experiences of childhood abuse including: physical, emotional and sexual abuse, experiences of physical and emotional neglect and “household challenges”, such as: domestic violence, substance use, mental illness and/or criminal behavior within the household (Felitti et al., 1998).

In the ACE report, Felitti et al. (1998) stated that “adverse childhood experiences are common and they have strong long-term associations with adult health risk behaviors, health status, and diseases” (p. 254). Felitti et al. (1998) found the more “ACE’s” a person experienced

the greater the likelihood they would develop negative health and wellbeing effects such as: physical illness, mental illness, substance abuse, unintended pregnancies, and financial and school difficulties (Felitti et al., 1998). It should be noted that many of the mental health issues that young people experiencing homelessness develop such as panic and anxiety disorders, depression, PTSD and substance use are found in the ACEs study to be linked with complex trauma (Felitti et al., 1998; Musicaro et al., 2017).

For complexly traumatized young people, the ACE study reinforces what we, as case managers know to be true already: the health and wellbeing effects of complex trauma have a significant impact on the young people we work with. In my experience the overwhelming majority of young people experiencing homelessness I have worked with have at least four “ACE’s”, with many reporting having experienced nine or ten ACEs. Case managers need to understand the impact of ACEs, including what Felitti et al. (1998) asserts are “the behavioral coping devices that commonly are adopted to reduce the emotional impact of these experiences” (p. 255). These “coping devices”, such as substance use, high risk sexual behavior and self-harm, caused by adverse childhood experiences, place a young person’s health and wellbeing at further risk, layering on top of the many other physical and emotional health issues caused by complex trauma itself (Felitti et al., 1998). A young person’s use of these adverse “coping devices”, along with the health risk factors that correlate with a higher ACE score, such as: intimate partner violence, sexual assault, financial instability and difficulties in school and work, once again highlight the ripple effect that complex trauma has on youth experiencing homelessness (Felitti et al., 1998). In addition, it cannot go unnoticed that the realities that a young person with a high ACE score experience, are the very same realities that young people experiencing homelessness experience as well

Addressing Complex Trauma in Case Management

Trauma experts maintain that for survivors of complex trauma, particularly for young people, any intervention or treatment, must prioritize physical and emotional safety first (Cook et al., 2003; Courtois & Ford, 2013; Herman, 1992). After which we can address a young person's relational, emotional, behavioral and cognitive impairments which in turn will help in addressing any of the critical issues impacting youth experiencing homelessness, like substance use, mental health, employment or stable housing. In explaining the profound consequences of complex trauma, Courtois and Ford (2013) state "cumulative forms of trauma and traumatization... deprive victims of their sense of safety and hope, their connection to primary support systems and community, and their very identity and sense of self" (p. 10). In many ways, Courtois and Ford call us as case managers to restore young people's sense of safety and hope, enhance their connection to support systems, and facilitate the development of their own identity and sense of self. Furthermore, as highlighted throughout this chapter, we as case managers, must identify, understand and respond to young people's trauma responses, such as substance use and high risk behaviors (Cook et al., 2003; Hopper et al., 2010).

In framing our understanding of complex trauma and the implications it has for our work as case managers, we must not ignore a young person's basic emotional responses, that is the feelings a young person has in the moment as a result of experiencing a traumatic situation(s). Some of these feelings could be: fear, powerlessness, shame and hopelessness (Courtois & Ford, 2013; Herman, 2013). As case managers, we cannot let our zest to identify and address a young person's impaired functioning, overtake the human response we must provide young people who have experienced the most horrific and unimaginable violations of their own humanity. It is our "human response" with young people who have survived complex trauma: empathizing with

them, attuning to them, connecting with them, listening to them, believing them, empowering them and supporting them, that is at the core of our purpose as case managers. In my experience, this human response is the only thing that allows for future engagement with a young person. It is the foundation at which all other work (i.e. assisting them in obtaining stable housing, budgeting their money, helping them obtain employment, etc.) happens. In providing a complexly traumatized young person a human response, we not only honor their humanity but we honor ours as well. In coming from an authentic, open, empathetic and loving space, we begin to restore a young person's sense of safety and hope.

Effects of Complex Trauma on Pedro

I started working with Pedro, whose story of childhood survival was highlighted earlier, just after he turned 18 years old. Unlike many young people experiencing homelessness, Pedro was eager to build a relationship with me and was quite open about everything that had happened to him growing up. Pedro experienced deep violations within his attachment and relational experiences, particularly with those who were supposed to care for him and love him. These violations of physical and emotional safety (i.e. physical, emotional and sexual abuse) as well as abandonment by both his mother and the child welfare system, caused him to develop a disorganized attachment style, which directly influenced his sense of safety and trust in others, impacting much of his behaviors and attitudes. This reality made establishing safety within our relationship an essential first step. In creating this safety, it was important for me, as his case manager, to be consistently nonjudgmental, respectful and unconditionally supportive and caring.

Due to Pedro's experience of complex trauma, I quickly realized he was in a chronic state of fear and stress and thus was almost always operating from his survival brain. In fact, there

were several months that he avoided leaving the shelter, for fear his family would find him and kill him. Initially Pedro's main goal and purpose of being in the shelter was to stay hidden from his family. All his physical, emotional and mental energy was directed towards this. Attending "life skills" groups, applying for a part-time job, obtaining food stamps, etc., all important steps in becoming more independent and transitioning out of experiencing homelessness, were perceived by Pedro as a threat, as they took his energy and focus away from staying hidden from his family. Pedro responded to these "threats" in various ways from aggression and oppositional behaviors to avoidance and engagement in self-harming behaviors. Pedro's survival behaviors caused conflict with both shelter staff and other youth and greatly impacted his ability to move forward on his case management goals.

One of the first things I learned in working with Pedro is he had significant issues with both his physical and mental health. Pedro often would tell me he "didn't feel good". He complained of headaches and physical body pain, as well as had eating issues and sleep disturbances, all of which are common with complexly traumatized youth (Cook et al., 2003). Pedro also presented with mood disturbances and had significant PTSD symptoms, including hyper arousal and traumatic flashbacks. Pedro's sleep disturbances included anxiety around sleeping, the inability to fall asleep and nightmares related to the trauma he experienced, all of which posed significant challenges for Pedro. To avoid "bedtime" at the shelter, Pedro often would break the shelter curfew or would refuse to go to his room when it was time for bed. Pedro's refusal to follow the "bedtime" rule was interpreted by staff as Pedro being "defiant" and his "defiance" was met with punishments, which further stigmatized and isolated him.

In addition, Pedro's sleep disturbances often caused him to be physically and emotionally tired during the day and thus unmotivated to follow through on various case management goals

he set for himself, like applying for food stamps. There were many times in which Pedro wanted to follow through on one of his goals, but was just too exhausted to do so. Because Pedro's sleep disturbances were such a significant barrier to his daily functioning and wellness, and put his housing at risk, as it caused much conflict with staff and other youth, we began to address it in case management. I provided Pedro with psycho-education on sleep and trauma, helped him to develop healthy coping strategies around sleep anxiety and nightmares, empowered him to negotiate with shelter staff around bedtime rules and expectations, provided him referrals for medical care and encouraged him to follow through on mental health support (which required psycho-educational information on mental health and therapy, including destigmatizing therapy and mental health).

Along with the health effects described above, Pedro had impairments in his cognitive, emotional, behavioral, and relational functioning, all the likely result of the complex trauma he experienced. The majority of the relationships that Pedro developed were unhealthy, with some becoming very toxic for him. He often would engage in romantic relationships that were in some way exploitative of him (i.e. his partner using Pedro for his money or housing, Pedro putting his job at risk to spend time with his partner, etc.). At one point, Pedro risked the housing he had through a youth program, by allowing his then boyfriend to spend the night with him. During our case management sessions, I helped Pedro develop his capacity to set healthy boundaries with others, particularly those individuals he was dating at any given time.

Pedro's emotional and behavioral regulation was a constant challenge for him. Like many young people who have experienced complex trauma, Pedro was easily triggered. He often struggled to understand, process, and manage his internal emotional state. It was equally as difficult for him to express his emotions to others, even to myself, whom he trusted. Depending

on the situation and/or trigger, Pedro would regulate his emotional state by engaging in range of behavioral responses from physical and verbal aggression and property destruction to self-harming behaviors, to isolation and avoidance to extreme compliance.

Pedro's struggle to obtain and sustain employment was a major focus of our work together and a reminder to us as case managers that deficits in functioning due to complex trauma can be a major barrier to accomplishing specific goals/tasks related to transitioning out of experiencing homelessness. It is important for case managers to assist young people in creating a resume, filling out job applications, accessing appropriate interview/work clothing and prepping for interviews. However, it is equally important for case managers to assess and address a young person's impaired competencies in areas of communication, emotional regulation and self-concept, as all are barriers in obtaining and sustaining employment for young people. In working with young people experiencing homelessness, we must recognize that a young person's difficulty in obtaining and/or sustaining employment (or any other specific goal/task) might be related to their cognitive inability to express themselves in an interview or their lack of basic social skills when interacting with someone new, or the inability to regulate their emotions when someone "triggers" them, or their lack of self-confidence.

When Pedro had difficulty obtaining employment, the initial focus was not on the various developmental and functioning deficits at the root of his employment difficulties but was instead directed at Pedro's "lack of motivation" and his "unwillingness" to work at certain jobs. Often, we, as case managers fail to be curious about a young person's behaviors, thought processes and manner of engagement. We fail to connect those behaviors, thought processes and engagement to their past and current experiences of trauma. Understanding the "why" of a young person's difficulty in accomplishing a goal is overlooked. Being curious and exploring with the young

person why they are having difficulty moving forward on their goal is critically important. Encouraging youth to reflect on how current and past behaviors effect their future can also be helpful. By this exploration in working with Pedro, I found out he never had a job before and I realized that much of his struggle was directly related to the consequences of complex trauma- low self-concept, inability to self-regulate and limited and blunted life skills.

Over time Pedro shared with me that he often did not feel he was “good enough” or “knew enough” to do a particular job, even for jobs that required no experience or specific skills. He shared that sometimes he felt that he could not express himself well in interviews, as he was self-conscious of his language and communication abilities. He shared that he often felt very uncomfortable around grown men, as they reminded him of his father and the abuse he had endured and thus would not turn in applications to them or interview with them. In working with Pedro, I realized the mistake that many of us providing case management services often make in working with youth is we focus on supporting and building a young person’s employment related capacities (or other specialized skills), without recognizing, understanding, and responding to the deep and lasting impact that complex trauma has on their ability to accomplish these skills.

In working with Pedro, I was reminded that my job as his case manager, above all else, was to help him address his most immediate need as a complex trauma survivor: safety. For without safety, nothing else could be accomplished and nothing else would really matter. The very first step in this process was us to establish and sustain a safe and positive relationship. After which we developed a plan to address and enhance his need for safety. I helped him to communicate his needs with shelter staff. I advocated for him and connected him to other support systems, such as medical and mental health support, public benefits and mentoring, all of which over time he engaged in. I helped him develop his competencies, basic life skills and

emotional regulation. I empowered him with knowledge around trauma, his triggers and healthier ways to manage those triggers.

Over the course of our work together, Pedro slowly began to feel safer, within himself, with others and out in the world. He learned to identify and better manage his triggers. His sleeping and eating improved. He regularly engaged in trauma-focused therapy. He applied for SNAP benefits and began participating in the life skills groups at the shelter. And finally, after over a year (which many program administrators believed was far too long) Pedro was able to obtain and sustain his first part-time job.

Engaging Youth Experiencing Homelessness

Services and support for young people experiencing homelessness are not only critical to their basic survival but can help to facilitate a youth's healing and personal growth, ultimately helping them to transition out of experiencing homelessness (ACF, 2016; Aviles & Helfrich, 2004; Hopper et al., 2010; Thompson, McManus, Lantry, Windsor, Flynn, 2006). Yet, engaging youth in these services, including case management, can be a challenge. The most significant challenge in engaging with youth experiencing homelessness is their lack of trust, often related to their experience of complex trauma (Aviles & Helfrich, 2004; Bender et al., 2014; Herman, 1992; McManus & Thompson, 2008; Thompson et al., 2006). For youth experiencing homelessness their lack of trust is a means of survival, as many of them have been abused, neglected, victimized, exploited and otherwise betrayed by adults who they once trusted to protect and care for them (Bender et al., 2007; Courtois & Ford, 2013; Herman, 1992; Kidd, Miner, Walker & Davidson, 2007). Young people often do not seek out services or engage very little with service providers, for fear of being judged, further mistreated, or reported to child welfare, immigration officials or law enforcement- systems that have often caused great trauma in their life (Bender et al., 2007; Thompson et al., 2006; Thompson et al., 2010).

Although engaging with youth experiencing homelessness can be a significant challenge, trust between a young person and their case manager can be successfully developed (Aviles & Helfrich, 2004; Herman, 1992; Kidd et al., 2007). In fact, the development of trust between a young person and their case manager is the bedrock of a safe and positive relationship (Courtois & Ford, 2013; Herman, 1992). And as case managers, we know it is the safe and thus transformative relationship that we develop with the young person in which all our work takes place (Herman, 1992; Kidd et al., 2007; Thompson et al., 2006). In reference to engaging youth,

Aviles and Helfrich (2004) maintain “staff’s approach to working with youth greatly influences youth’s self-perceptions which also impacts their desire to seek assistance from services providers” (p. 335). Research, along with experience in the field, suggests that initial and continued youth engagement is often facilitated, enhanced and cultivated by specific “youth engagement” best practices: *youth-centered strengths-based perspective, harm reduction, trauma-informed care and cultural humility* (Aviles & Helfrich, 2004; Courtois & Ford, 2013; Bender et al., 2014; Hopper et al., 2010; Kidd et al., 2007; Thompson, et al., 2010).

Youth Engagement: Best Practices

A youth-centered, strengths-based perspective is imperative to employ when working with youth experiencing homelessness (Aviles & Helfrich, 2004). For young people who have experienced complex trauma, such as abuse, neglect, exploitation and oppression, this approach runs counter to many of their past experiences both with individuals as well as within systems such as child welfare and juvenile/criminal justice. Ultimately it is an approach that places the young person at the center of service provision and seeks to identify and enhance the inherent strengths and capacities of a young person (Aviles & Helfrich, 2004).

A youth-centered approach, broadly refers to developing and providing services and support that is “youth-centered” or driven by the individual youth’s needs (Kidd et al., 2007; Thompson et al., 2005). In addition, a youth-centered approach ensures that engagement and services, including case management is easily accessible to the young person and is tailored to the young person’s developmental stage (Aviles & Helfrich, 2004). Aviles and Helfrich (2004) remind case managers working with youth that we must “consider a youth’s ability to access staff when motivated to seek out services”, underscoring the importance of being youth-centered (p. 335).

The “strengths-based perspective” a dominant practice in human services, is an approach that calls on case managers and youth to work together to identify and build off the individual young person’s personal as well as communal strengths and resources (Bender et al., 2007; Rapp, Saleebey, & Sullivan, 2005). Brun and Rapp (2001) state the “strengths perspective is based on the belief that the individual [youth] possess abilities and inner resources that allow them to cope effectively with the challenges of living” (p. 279). This philosophy focuses on empowerment and recognizing a young person’s potential. A youth-centered, strengths-based approach helps case managers build rapport with youth, including helping youth to identify their strengths and personal passions, which in turn helps the case manager and youth develop a trusting relationship (McManus & Thompson, 2008; Thompson et al., 2006).

Harm reduction is a practice that intentionally uses a “low-barrier” approach in engaging with youth experiencing homelessness, with the end goal of establishing trust and helping youth to achieve greater safety and wellness (McKenzie-Mohr et al., 2012; RHYTTAC, 2013). The Runaway Homeless Youth Training and Technical Assistance Center (RHYTTAC) states, “harm reduction refers to policies and practices that aim primarily to reduce adverse health, social and economic consequences of high risk behaviors (i.e. running away, substance use, high-risk sex, survival sex, etc.) and benefits people engaging in high risk behaviors as well as their families and communities” (RHYTTAC, 2013). A harm reduction practice calls on case managers to meet young people where they are at, without judgement or expectation, allowing for trust to be developed (RHYTTAC, 2013; Kidd et al., 2007).

Harm reduction enables a case manager to establish an initial connection with a young person, which helps to build trust between the young person and the case manager, which then could lead to the reduction of high-risk behaviors and further engagement in case management

services (Bender et al., 2007; Coates & McKenzie-Mohr, 2010; RHYTTAC, 2013). Harm reduction allows for young people to make mistakes without judgement and enables them to experience small successes when trying to make difficult changes, such as reducing their dependence on substances or engagement in sex work (Kidd et al., 2007). For young people this practice leads to increased sense of self-efficacy, self-acceptance and hope that life can be different for them. In addition, as highlighted earlier, many of the circumstances that youth experiencing homelessness experience and/or are subjected to, from substance use and mental illness, to commercial sexual exploitation and criminal behavior, to homelessness itself, carries an extreme amount of social stigma and marginalization, making the practice of harm reduction critical when working with these young people (Kidd et al., 2007). Underscoring the importance of harm reduction principles, one study of youth experiencing homelessness found that youth “were drawn to providers that conveyed openness and acceptance, emphasized establishing trust, and instilled hope” (Thompson et al., 2006, p. 39).

Trauma-informed care is a lens in which to interact and provide services and support to trauma survivors, including youth experiencing homelessness. A trauma-informed approach seeks to recognize, understand and respond to the impact that trauma, particularly complex trauma has had on the lives of young people (Hopper et al., 2010; SAMHSA, 2014). In addition, a trauma-informed approach aims to eliminate instances of re-traumatization within systems of care (Hopper et al., 2010; SAMHSA, 2014). The overall goal of trauma-informed care is to help young people feel safe, both physically and emotionally, and move them towards a place of healing and empowerment (Bender et al., 2014; Coates & McKenzie-Mohr, 2010; Hopper et al., 2010). This approach is critically important in all aspects of service provision, but especially when trying to engage youth in services, as before youth can develop and follow through on their

goals, they must first feel safe. In addition, trauma-informed care's principle of eliminating instances of re-traumatization and our role, as case managers in this process, can illustrate to youth in real time that we recognize the importance creating safety for them, which helps them feel comfortable and thus engage in services. Due to trauma-informed care's central role within this project it will be discussed at length in a later chapter.

Cultural Humility, is born out of the more widely known concept- "cultural competence", a central objective for many human service practitioners, including case managers. Within our work with young people, the concept of "culture" is not just inclusive of race and ethnicity, but of a young person's sexual orientation, gender identity, language, religion/spirituality, etc. In addition, due to their age and developmental stage in life, "youth" themselves, as a group, can also be considered their own culture, for they, as a group have a specific language, way of being and interacting, engagement style and practices. In fact, understanding and respecting "youth culture", is critically important in engaging with youth as well as providing them services and support (Thompson et al., 2006). NASW (2015) defines cultural competence as "the process by which individuals and systems [i.e. case managers and youth-serving agencies] respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, spiritual traditions, immigration status, and other diversity factors in a manner that recognizes, affirms and values the worth of individuals, families, and communities and protects and preserves the dignity of each" (p. 15).

While the intentions behind "cultural competence" come from a good place, the concept is incomplete, because we, as practitioners can never really be fully "competent" in another culture, as culture and more specifically how that culture is experienced and lived out by individuals, families and communities is unique and ever-changing. Furthermore, "cultural

competence” has become more of a requirement that a practitioner fulfills, often a course or two in their training, after which they are deemed “culturally competent” practitioners, rather than a genuine attempt to explore cultural diversity and how aspects of an individual’s cultural identity(s) influence their internal self and impact how they experience the world. Thus, I have found the concept and practice of “cultural humility” to be extremely helpful in engaging with young people and particularly relevant in developing a deeper connection with them.

In many ways, cultural humility was developed to expand and refocus intentions around providing culturally “competent” services to individuals and communities, recognizing that we, as practitioners can never achieve “competency” in another culture but instead must be “humble” in our approach, understanding and response to cultural diversity. Because achieving “competency” is not the objective, cultural humility asks practitioners, including case managers, to be open and willing to continually learn and grow as it relates to understanding their own culture as well as the culture of others (Ortega & Faller, 2011; Tervalon & Murray-Garcia, 1998). In short, the practice of cultural humility calls on case managers to engage in self-reflection, become lifelong learners, address power imbalances and participate in systemic change (NASW, 2015; Tervalon & Murray-Garcia, 1998).

Ortega and Faller (2011) maintain that cultural humility “encourages workers [case managers] to take into account an individual’s multiple identities and the ways in which their social experiences impact their worldview, particularly as it relates to their expression of their culture” (p. 33). Cultural humility recognizes that a young person’s cultural identity is complex and unique to them as an individual. It asks case managers to be open and willing to learn about a young person’s culture, often from the young person themselves. For me, as a case manager, often with a different cultural, racial and economic background (among other things) from the

young people I work with, the practice of cultural humility, particularly committing myself to being “humble” as it relates to cultures that are different from my own is imperative in not only better understanding the young people I work with but also in building a safe relationship with them. In being humble around issues of race and ethnicity, gender, ability, etc. I have allowed myself to be vulnerable with the youth and open to viewing and understanding the world through their eyes.

Embedded into the practice of cultural humility, is the theory of intersectionality. The concept of intersectionality, refers to the connection between a young person’s various social identities, like their race, gender and sexual orientation, and how those identities intersect with each other and then how these social identities link with the societal power or oppression that the young person experiences (Jones, 2016). Jones (2016) maintains “an intersectional framework foregrounds not only the lived experiences and identity considerations of individuals, but more so the particular issues that are disproportionately encountered by certain groups of individuals given inequitable power structures” (Jones, 2016, 29). For example, as already noted, within the youth experiencing homelessness epidemic itself, there are certain groups of young people- youth of color, LGBTQ youth and undocumented youth- all groups who experience added vulnerability and marginalization due to societal power inequities and oppression, in addition to experiencing homelessness.

In being “culturally humble” or vulnerable with the young people we have the opportunity to understand, often through open and genuine conversations with youth, how their various social identities (i.e. their race/ethnicity, sexual orientation, gender identity, and/or immigration status) intersect with each other, often exacerbating their vulnerability and marginalization in society. My practice of cultural humility has allowed me to be aware of and

sensitive to how a youth's intersecting identities contribute to their vulnerability and marginalization. I have often found that my awareness and sensitivity, often signals to youth, that I am open to hearing about their experiences and have a genuine interest in learning from and supporting them. I have found that my practice of cultural humility paves the way for the development of a more authentic relationship with young people and one that ultimately assists in providing case management services to youth. This project's appreciation for and use of cultural humility, which includes the application of an intersectional framework in engaging with young people is intentional, as it not only assists us in engaging with youth, but directly connects to social justice work (Carbado et al., 2013).

Youth Engagement: An Example

When I first met Vivian, she was just 17 years-old and wanted nothing to do with me. She was emotionally closed off, dismissive and rude. She shared almost nothing about herself and evaded me, her case manager, whenever she could. When we did interact, she would act extremely bored and disinterested. After a few months of "working" with her, trying my best to genuinely connect with her, I began to wonder, if we would ever be able to connect past a forced "hi, how are you?" "I'm fine", level of interaction.

As a young African American girl who had experienced extensive complex trauma throughout her short life, including emotional and sexual abuse, community violence, parental mental illness and incarceration, educational neglect, racism, homelessness and commercial sexual exploitation, Vivian had many reasons to be emotionally closed off, dismissive, rude, and afraid of connecting. I quickly realized her responses to me trying to engage with her, were self-protective survival behaviors. They were attitudes and behaviors she developed to help her physically, mentally and emotionally survive. All her past experiences had taught her not to be

vulnerable with others, not to become attached, not to trust others, for if she did, she surely would be hurt in some way. So, Vivian was not vulnerable with me. She did not become attached. And she did not trust me. Who could blame her?

As her case manager, I knew that our work together would not be nearly as effective or meaningful if we did not establish a connection with each other. And so, I made a commitment to respectfully and intentionally engage with Vivian, in the hopes that we would eventually build a safe and trusting relationship. A relationship that might be the foundation to assist her in her own healing and transformation.

The over-arching approach I used in engaging with Vivian, as with all the young people I seek to connect and build a relationship with was trauma-informed care, however the use of harm reduction, a youth-centered strengths-based approach and cultural humility were all extremely helpful as well. In many ways, the application of harm reduction principles became the foundation of our early engagement and led us to eventually establish trust with one another. Vivian's experiences of educational neglect, homelessness, criminalization, sexual abuse and exploitation and racism, caused her to feel isolated, stigmatized and marginalized by society. Her almost palpable feelings of shame and stigma, made the harm reduction's principles of openness and nonjudgement particularly relevant when engaging with her and subsequently building a trusting relationship with her. It seemed that for a long time within our relationship, Vivian was always ready and waiting for me to judge or shame her for something she had experienced or engaged in. Instead I would always respond to her from a place of openness and curiosity, an approach that was nonjudgmental, affirming and respectful. An approach that aimed to meet her where she was at and build up trust between us. In using this approach, I was able

establish a tone that was consistently nonjudgmental and respectful, allowing for Vivian to be heard and seen, which in the end helped her to trust me.

As a young person who had been exploited for years, often being pressured or having expectations placed on her to perform or do something (i.e. engage in sexual acts/violence, steal, etc.) in exchange for money, food, shelter, protection, and/or love, the “low-barrier”, no expectations principles of harm reduction were a welcome change for her. The “low-barrier” approach I used with Vivian, especially in the first months of our work together, allowed Vivian to engage with me, as well as with the services offered (i.e. connection to resources, psycho-educational groups, etc.), on her own terms, as much or as little as she felt comfortable with. It was an approach that did not force Vivian to do something, like agree to meet for case management in order to access services or be treated with kindness. This “low-barrier” approach allowed Vivian to be in control, thus comfortable, which ultimately increased her engagement with me as well as the services and supports I offered her. In reflecting on my work with Vivian, I believe that my rigorous practice of harm reduction with her, particularly, being open and nonjudgmental was essential in helping me to initially engage her in case management services and ultimately was the foundation of our relationship.

Along with using a harm reduction approach to engage with Vivian, I also relied heavily on applying a youth-centered, strengths-based approach with her. In using this approach, I placed Vivian- her needs, her opinions, her feelings, her experiences, her strengths, her capacities and her goals at the center of our work together. In doing this, I set an expectation, that our work together would be directed by and focused on, Vivian, which for a young person who had been exploited and marginalized for years was a new, but empowering experience.

As a survivor of trauma, Vivian presented with many cognitive, emotional and behavioral issues and problems in which she needed assistance and support addressing. As we began to work together, it became clear to me that after years of neglect, abuse and exploitation, Vivian was very disempowered, and struggled in identifying positive characteristics and strengths for herself. Yet, the more we connected, the more I was able to help her identify the many personal strengths and capacities that she possessed. Even when she would share with me an interaction she had that was problematic, like cussing someone out on the train (for which she wanted me to shame her for doing), I would often find a way to point out a strength of hers, like being able to stand up for herself, before helping her explore possible other ways she might have handled the conflict.

In our work together I helped Vivian to leverage her own strengths and capacities to address many of her “problems”, which were mostly just responses to complex trauma. Like all the young people we work with, Vivian’s strengths and capacities far outweighed her “issues” and “problems”. In identifying, affirming, validating and focusing in on her positive characteristics and skills, those that were a source of pride for her, she was able to feel truly seen, understood, supported and cared for, which was extremely helpful in strengthening our therapeutic alliance. Inherent in using a youth-centered, strengths-based approach, is the concept of empowerment. And for a young person like Vivian, becoming empowered, that is being able to identify, develop and enhance her personal strengths and capacities was both healing and transformative.

The practice of cultural humility was also helpful in initially engaging with Vivian as well as strengthening our therapeutic alliance as our relationship continued over the years. Early on in our relationship, I realized that her racial identity and the racial identity of other people

around her was always on her mind. This made recognizing, understanding and responding to how Vivian's race and gender influenced her internal thought processes and her external experiences, to be extremely helpful for me in building an authentic relationship with her. In addition, through observation and reflection it became clear that Vivian had had virtually no positive interactions, let alone any kind of relationship with someone like me (a white gay male) ever. Due to this reality I was sensitive to and respectful of the feelings and thoughts Vivian was having not just at the beginning of our relationship, but throughout our relationship, as race and racism would often be central to Vivian's experiences and thus our conversations.

Throughout our relationship, Vivian would bring up race often, especially how she experienced "being Black" in society. In these conversations, I would listen and validate her thoughts and feelings. As our relationship developed, I would also lightly challenge those thoughts or feelings, especially with regards to her internalized oppression. The more our relationship strengthened, the more I realized just how much racism had influenced the way she saw the world, what she expected from others, what she believed about herself and the access and opportunities she was offered.

This all came together for me one day when we were out job searching together, which rarely happened, as she often avoided going to apply for jobs. For well over a year, Vivian had struggled to make progress on her employment goals, which had become a small point of contention/frustration between us. As we walked from business to business, dropping off resumes and applications and discussing nail polish colors, I asked her why following through on her employment goals were such a challenge for her. Vivian then shared with me what it was like for her, a "black girl" to go into places and apply for jobs. She shared with me that she often felt uncomfortable going into places to ask for job applications or drop off her resume. She

shared that most of the time she was applying to places where she saw no “Black” people, which made her feel “weird”. She stated that she often felt that everyone was staring at her. She talked about feeling judged and stigmatized. Throughout our conversation, she was extremely open and honest. I asked some clarifying questions, but mostly just listened to her. By the end of our conversation, I came to understand that some of her challenges around employment, were not related to her skill set or her motivation to get a job, but were more so related to how she experienced the world as an African American girl. In reflecting on this conversation with Vivian, I realized that my understanding and use of cultural humility, laid the groundwork for her to feel safe and comfortable enough to share her thoughts and experiences with me in an unfiltered and candid manner. And it was the application of cultural humility, including the use of an intersectional framework, that allowed for me to be open and willing to truly hear, appreciate and validate what she shared with me.

Sustaining a Safe Relationship with Youth Experiencing Homelessness

The youth engagement best practices highlighted above are both the foundation, as well as the building blocks in creating a safe and healthy relationship between youth and case managers. Human connection and relationship is at the heart of this project, from the individual interventions provided to youth, to the engagement in social action. Every opportunity to authentically engage with youth, is an opportunity we, as case managers have to further our relationship with them. For young people who are disconnected and isolated, these interactions can be affirming, reparative and healing and build essential life skills, including their capacity to develop other safe relationships in the future (Freedberg, 2009; Herman, 1992; Jordan, 2010). Kidd et al. (2007) states, “to be effective, the worker [i.e. case manager] must be open to the

youth; give them space, and take the time to build the relationship that is necessary to the development of a real understanding regarding what she or he needs” (p. 18).

Developing and sustaining a safe relationship with a young person, particularly a relationship that lasts overtime can no doubt be challenging. In reflecting on the literature as well as my own practice with young people I have come to identify some core concepts/practices in developing and sustaining a safe relationship with youth experiencing homelessness. These core concepts/practices are: self-awareness, mutual empathy and healthy and humane boundaries. It should be noted that these specific concepts and practices align with and are embedded into the youth engagement best practices highlighted above (i.e. strengths-based perspective, trauma-informed care, harm reduction and cultural humility) and are concepts and practices that are the heart of my own case management practice with youth experiencing homelessness.

Self-awareness

As a case manager, I have found self-awareness to be a critical aspect in developing and sustaining relationships with young people. We, as case managers cannot enter into a safe, mutual, participatory, transformative relationship with a young person, if we ourselves, are not tuned-in to our own feelings and experiences and how those feelings and experiences can, and often do, influence our work with a young person (Freedberg, 2009). A practice of self-awareness allows us to explore our own feelings and thoughts about various behaviors and attitudes that young people might engage in or hold. It helps us identify our own triggers as well as our motivations for doing the work in the first place. In becoming more self-aware, we, as case managers can get in-front of our own feelings, thoughts, perceptions or attitudes which we could project onto the young people, thus negatively impacting our relationship with them. For

example, if a case manager is not aware of and/or does not have a plan to manage a particular trigger, especially one that is connected to a young person's behavior, the case manager might react in a manner either consciously or unconsciously, that targets, stigmatizes or marginalizes the young person. In being more aware of who we are, as case managers, we can better connect with and thus serve young people.

In addition, self-awareness, which is embedded into our practice of cultural humility requires us to explore and critically examine who we are and how we show up in a space with young people (NASW, 2015; Orgeta & Faller, 2011). It encourages us to reflect on our own social identities (i.e. race, ethnicity, culture, gender, socio-economic status [SES], etc.) and the power and/or vulnerability we have in spaces, particular within our relationship with youth. In my experience, greater self-awareness, especially around how I show up in a space, with regards to my various social identities (i.e. my race, gender, SES and education) has helped me to be more sensitive, conscious and responsive to differences in identities, experiences and power between myself and youth. Ultimately, this practice has led me to build relationships with young people that are more meaningful and authentic.

Mutual Empathy

Another important practice in building and sustaining a safe and positive relationship with young people experiencing homelessness is relational cultural theory's (RCT) concept of *mutual empathy*. Due to the project's strong focus on connection and relationship building the concept of mutual empathy is important to employ, as it helps in developing an authentic, caring and supportive relationship with young people. Furthermore, the practice of mutual empathy is particularly relevant due to young people's experiences of past and current trauma, causing them to feel disconnected, isolated and stigmatized (Jordan, 2010). Dr. Judith Jordan, (2010) states

that “in order for empathy to facilitate change, each person [case manager and youth] must see, know, and feel the responsiveness of the other person. Mutual empathy involves mutual impact, mutual care, and mutual responsiveness” (p. 4). In my experience, I have found this “mutual impact, mutual care and mutual responsiveness” between myself and the young person, to be experienced through words and actions and allows for emotional attunement, which helps strengthen our therapeutic alliance. Father Gregory Boyle, Jesuit Priest and founder of HomeBoy Industries, a Los Angeles based gang intervention program, stated, “The question isn’t: can you [the service provider] reach them [the youth]? The question is: can you be *reached* by them?”. This idea of being “reached”, of being emotionally impacted and moved, by a young person is the essence of mutual empathy. It is what helps to create and sustain a mutual, authentic and transformative relationship with a young person.

Freedberg (2009) states “empathy involves not only the ability to enter into the experience of another, but also the ability to communicate that understanding and create an atmosphere of validation and support” (p. 53). Freedberg’s conceptualization of empathy deeply resonates with me, as a case manager. In working with young people experiencing homelessness, I have found it essential to convey my understanding of a youth’s feelings or experience, through my words, body language, facial expressions and actions. By doing this I illustrate to youth not only that I understand or as they put it “*I’m down for the cause*”, but also that I will fight with them for what is important to them. Sadly, often what we are fighting for is understanding, respect and inclusion from other people, communities and systems that are intent on maintaining the youth’s separateness, vulnerability and marginalization. I have found that the practice of mutual empathy allows for myself and a young person to appreciate, understand and join together, despite our often-differing socio-cultural backgrounds and experiences (Freedberg,

2009). In joining with youth to advocate for what is important to them, our connection deepens, allowing for a space to be created that is safe and affirming, and one in which the young person can share intense emotions and thoughts that come up as they navigate life.

The practice of mutual empathy with youth, allows myself, as the case manager, to be a fully engaged participant within the relationship, and allows the youth to experience a response from me that is authentic and safe (Freedberg, 2009; Jordan, 2010). Mutual empathy, allows for me, as Father Boyle put it, to be emotionally “reached” by the young person and for the young person to know and feel that I have been “reached” by them. In my experience, this notion of being “reached” by young people happens when we experience moments of happiness and joy, or anger and sadness together. I have found this phenomenon of being “reached” as well as doing the “reaching” to be strongly related to restoring and enhancing the dignity of youth experiencing homelessness. For, when young people, can see and feel that they have “reached” someone, like their case manager, their own dignity and humanity is affirmed in the process.

There have been countless times I have been with a young person as they interact with someone from the public, like a school counselor, a doctor or a landlord. In the course of the conversation with this other person, they unintentionally say something that reminds the young person that they are homeless, such as, asking the young person for their permanent address or telling the young person not to worry about getting a loan for school, as they can just have their parents co-sign for them. When these moments happen my heart sinks, for it is almost certain that the young person was just reminded of all the trauma and loss that has caused them to experience homelessness and the shame and stigma that homelessness itself carries. In these moments, I try to make eye contact with the young person to signal my recognition and understanding of their feelings. In these moments, the young person sees and feels that I too am

impacted by what was just said. They see and feel I too, am triggered. They see and feel, that I, just like them are responding to the feelings of stigma and marginalization that they experience daily. And in those moments, they see and often they feel, they have “reached” me.

Healthy and Humane Boundaries

Safe and positive relationships are developed with youth when safe and appropriate boundaries are established (Freedberg, 2009; Herman, 1992). Complexly traumatized youth almost always have experienced extreme boundary violations such as: abuse, victimization and/or exploitation, often perpetrated by trusted adults in their life, such as their parents/caretakers, teachers, coaches and church leaders, people who were supposed to protect and care for them (Cook et al., 2003; Courtois & Ford, 2013). The experience of these boundary violations (conceptualized as another form of trauma) can greatly influence a young person’s sense of safety, their ability to trust others, including their case manager, and how they relate within relationships moving forward (Courtois & Ford, 2013; Herman, 1992).

Boundary violations can also happen between the case manager and youth within the case management relationship. These boundary violations can be overtly egregious (i.e. abuse, victimization, exploitation, unwanted physical touching, discrimination) or can be covert and seemingly less extreme in nature, yet deeply harmful to youth (i.e. asking youth to keep secrets, disclosing personal information about yourself, treating youth differently based on “liking/not liking” them, etc.). Regardless of the “severity” of a particular boundary violation, it can be experienced by the young person as harmful, often mirroring other traumatic and abusive boundary violations they have experienced in the past (Herman, 1992). Thus, for complexly traumatized youth, safe and appropriate boundaries can in-itself be an intervention we provide

within case management, as it can be reparative for the young person (Herman, 1992). It can illustrate to the young person that being safe within a relationship is possible.

The establishment of “healthy and humane” boundaries with young people experiencing homelessness is critically important to the development of a safe and positive relationship for the young person. These boundaries are integral to both a young person’s sense of safety within the relationship, as well as our own wellness and sustainability as case managers. (Please note, a more fulsome discussion of case manager wellness and self-care will be expanded upon in a later chapter). To ensure safety within our relationship with youth, we as case managers must provide structure and limits (both physical and emotional) to our relationship with young people. The limits we put in place in the context of our relationship with youth will likely be met with resistance by the young person, especially if their past relationships with others were “boundary-less”. Some youth will even set up (unconsciously) dynamics in which it can be very easy to violate boundaries with them, as they are trying to recreate (subconsciously) relationships (often unhealthy or exploitative) with which they know and thus are more comfortable with. However, if limits and thus boundaries are followed through consistently by the case manager it will eventually result in the youth feeling genuinely safe within the relationship (Herman, 1992). For the upholding of boundaries in a consistent and humane manner, honors the individual young person, as well as the integrity of the relationship, ultimately making the connection between the young person and the case manager stronger.

In establishing boundaries with young people, we seek to provide structure and limits to our relationship with them, with the goal of establishing and sustaining safety. We also seek to be youth-friendly, flexible, emotionally attuned and “reachable”. We seek to be humane. Each of us show our humanity to young people in different ways. Due to a specific situation, a case

manager might cry with a youth or hold their hand through a difficult time or give them a hug when they reach out for one. These are all instances in which I have showed my own humanity with young people over the years. Yet they are also instances that without careful examination and intention could have been at the very least unhelpful to the young person and at the very worst a boundary violation, mirroring an unhealthy relational dynamic of their past thus could trigger them or violate their sense of safety. For example, if a case manager begins to cry with a young person, the young person, then might feel that they need to comfort the case manager, thus assuming a “caretaking” or “protector role” with the case manager, of which they might have had with other adults (i.e. their own parent/caretaker) in life. This relational dynamic might mirror unhealthy and possibly exploitative relationships in the youth’s past, thus could trigger the youth and lead them to resent their case manager, causing them to “act out”.

The establishment of healthy and humane boundaries is without question one of the most important aspects of our work with young people. Our ability to establish healthy and humane boundaries within our relationships with youth relies heavily on our own judgement. This judgement comes from a continued practice of self-reflection and awareness not just of self, but of the individual young person we are working with, their past experiences of trauma and their triggers. It comes from being emotionally attuned to the young person. It comes from being intentional, measured and consistent in our responses with young people. In short it comes from adhering to a trauma-informed practice. And for me, it always comes from a place of putting the young person- their needs, their feelings, their experiences, their goals first.

Being “Reached”

The more I reflect on my work with young people experiencing homelessness, the more I come to realize Father Boyle of HomeBoys Industry was correct, “the question isn’t: can you

[the service provider] reach them [the youth]? The question is: can you be *reached* by them?”. I have been fortunate to have been reached by countless young people, some of whom I have included in these pages. The relationships that we have developed together have not only made me a more sensitive, compassionate and effective case manager, but have enriched my life in ways I cannot even describe. While I no doubt have provided young people well informed and appropriate interventions and support, that have developed their skills, enhanced their capacities and helped to transition them out of experiencing homelessness. It is the human connection I have developed with young people that stands out in my mind and is imprinted on my heart.

Antonio was one young person who reached me. Looking back now, it seemed unlikely that Antonio and I would develop a strong connection. When I met him, Antonio, a 23 year old Latino male and former gang member, was residing in a youth shelter after spending close to a year in jail. I was his second case manager, as his former case manager (someone he really liked) had recently left the field. From the very beginning of our relationship Antonio was closed off, abrasive and sometimes rude. He spoke very softly, often mumbling, as if he did not want me to really hear him or ask him questions. When I would provide him suggestions or advice, he would often let me know why whatever I suggested would not work for him, often speaking in a rude tone. It always seemed as if he knew better than me and he wanted me to know that he knew better.

In the time I worked with Antonio, he rarely asked for my help out right. Looking back now, I realize that much like Vivian his presentation and behavior with me was his way of protecting himself from being let down or hurt by me. I realize now, how difficult it was for Antonio to rely on someone else. However, in the months leading up to him moving out of the shelter, he asked me to accompany him to look at some rental units he could afford. I gladly

accepted his request. For the next few weeks, Antonio and I spent lots of time together going to view various studio apartments. In the course of those weeks our relationship strengthened. He opened up more than he ever had before, sharing with me what his life was like as a child, how/why he became gang-involved, his time in jail and his thoughts about the criminal justice system. He also asked me to help him fill out apartment applications and what questions to ask the landlord before looking at places. And when I provided him suggestions and advice, he took it without protest or qualifiers.

When we finally found the perfect room to rent I made plan to help Antonio move out of the shelter. The day he moved it was pouring rain. We loaded all his stuff into the car and blasted the radio all the way to his new place. It was still pouring when we got to his new place. Before getting out of the car I praised Antonio for all his hard work and accomplishments while he staying at the shelter (i.e. completing high school, obtaining stable employment and amassing a good amount of personal savings), all which led him to get his own apartment. I shared with him how proud and happy I was for him. He just smiled at me. After a moment of silence, he abruptly told me not to worry about helping him empty all his stuff from the car, as he did not want me to get all wet from the rain. I told him that of course I would help him get all his stuff out of the car. So, in the pouring rain, we moved all his stuff into his very own apartment. When we finished, we were both soaking wet, but I could tell Antonio was so happy. He finally had a place of his own. As I was about to leave I reminded Antonio that he could always reach out to me for support and to keep in touch. Antonio then reached to give me a hug and said “Thanks, for everything Frank”.

A few weeks after I helped Antonio move I was helping another young person move into his old room at the shelter. After getting settled in the room, the young person brought me a

baseball hat he found in the room. It was Antonio's hat. Holding his hat in my hand, I thought about when I first met Antonio (he was wearing this very hat). I thought about how difficult it was to initially engage with him, as he liked his first case manager "way more". I thought about, his willingness, eventually, to connect with me. I thought about the conversations we had during our case management sessions about food and cooking (he was in culinary school at the time) and how the only real purpose of those conversations was to develop a connection with him. I thought about the experiences he shared with me about his childhood. I thought about the care and support he offers others, particularly his grandmother. I thought about the hard time he always gave me for being "too nice" to him and the other youth. I thought about the music he liked. And I thought about his courage, honesty, work ethic, resiliency and humor. As I held his hat in my hand, I suddenly realized, Antonio had reached me.

Case Management with Youth Experiencing Homelessness

For Lucia, a 19-year-old, residing in a transitional living program (TLP) for youth experiencing homelessness, case management services played an integral role in connecting her with resources, developing her competencies and enhancing her capacities, all of which helped her transition out of homelessness. Lucia, like many youth experiencing homelessness had grown up in a violent and gang-ridden neighborhood where drugs and violent crime were rampant. When she was a young child, her father, gang-involved and drug dependent, was in and out of jail, and was eventually deported to Mexico. Throughout Lucia's childhood her mother battled addiction, causing Lucia and her younger siblings to experience chronic dysfunction and instability. Due to her mother's addiction, Lucia was forced to take on a parental role, often caring for both her younger siblings and her mother. As Lucia entered her teenage years, she began to assert her own independence, causing increased conflict between herself and her mother. The conflict between "parentified" Lucia, who grew frustrated of always having to care for her siblings, and a mother who was unpredictable due to her substance use, led Lucia to "act out" herself, and eventually she run-away from home.

Shortly after leaving home, Lucia landed at a youth shelter, where she stayed on and off for a few years. When Lucia was not staying at the shelter she stayed with her grandmother, who was by then caring for her younger siblings too, as Lucia's mother was serving time in prison on drug charges. By the time Lucia graduated high school, her mother was out of prison, sober and caring for her younger siblings. While Lucia was welcome to move back in with her mother, there was limited space in the new home and Lucia still resented her mother for the way she treated Lucia beforehand, so Lucia began to couch surf instead. After several months of couch

surfing, Lucia was accepted into a transitional living program for young people experiencing homelessness, where we began our work together.

When I met Lucia, even though she was working 32 hours a week, making slightly above minimum wage, and taking part-time classes at a local community college, yet she still faced many challenges, particularly around life skills. In meeting with me for case management she was engaged and open to building a relationship. She often came to our weekly case management sessions with specific ideas or goals that she wanted to work on and greatly enjoyed reporting back the progress she had made on her previous goals. Within case management, I supported Lucia in developing goals around: education, healthcare, emotional wellness, time management, money management and healthy relationships. As her case manager, I connected her to educational support and tutoring, assisted her in obtaining free medical and dental insurance, encouraged her to meet regularly with her therapist and linked her to a personal mentor. During our weekly case management sessions, I would help Lucia fill out a daily/weekly schedule which helped her manage her time better. We would also develop a monthly budget together, which often would need to be altered the following week, due to Lucia's challenge in sticking to her proposed budget. In addition, we spent a great deal of time processing the relationships within her life, particularly with her mother and explored various ways of setting healthy boundaries with her family.

During the time that we worked together, Lucia worked hard to move forward on her goals, both big and small. She was able sustain her job, even getting a promotion and a pay raise, while going to school and receiving good grades. While time management and budgeting were major challenges for her throughout the time we worked together, she did have awareness of these challenges and was willing to confront them, making substantial improvements. Lucia

also became increasingly more self-aware and confident, which led her to become a strong advocate for herself and others. She learned to set boundaries with others, especially her mother, while still staying connected to her and her young siblings. Amongst her peers, Lucia was a positive role model, often encouraging her peers to follow through on their own goals and giving them advice.

In the process of providing case management services to Lucia, she and I developed a strong relationship. We went on hikes together and had endless discussions about her future. I helped her set up a bank account, took her to visit her new baby sister in the hospital, went with her when she bought her first car and took her on countless trips to the grocery store where we often processed her spending habits. I helped Lucia apartment search and then assisted her move into her new place. And when she graduated with her associates degree a year later, upon her request, I attended her graduation, witnessing her accomplish one of her longest and most hard-fought goals.

Case Management

In youth experiencing homelessness services, case management has been identified as a critical intervention provided to young people, as it helps to address their intersecting and complex needs (ACF, 2016; Arnold, Walsh, Oldham & Rapp, 2007; Bender et al., 2015a; Slesnick, Kang, Bonomi & Prestopnik, 2008; Thompson et al., 2010). Virtually all agencies and programs serving youth experiencing homelessness offer young people some form of case management services. I have found these services, when provided in the context of the relationship between the young person and the case manager, essential for youth experiencing homelessness, as it links them to resources, builds their skill set, and ultimately helps them transition out of homelessness.

“Case management” is an umbrella term that often encompasses a variety of different components including: **outreach**-identifying and connecting with individuals in need of services/support, **engagement/building rapport**- developing a therapeutic alliance with the individual, **assessment**- identifying an individual’s needs, strengths and barriers, **planning**- assisting individuals in developing and following through on goals, **service navigation/linkage**- linking individuals with community services and resources, **education**- providing psycho-education and information, **supportive counseling**-providing practical and emotional support and **advocacy**- advocating for individuals within systems (Lukersmith, Millington & Salvador-Carulla, 2016; de Vet et al., 2013).

The inclusion and execution of these components relies heavily on the context of the work, the population being serviced and the capacity of the “case manager” (Lukersmith et al., 2016). For example, a nurse providing case management services to older patients with diabetes will look much different than a social worker providing case management services to youth experiencing homelessness. Historically, case management within the field of social services (i.e. homeless services) has been the most holistic, comprehensive and “client-centered” form of “case management” (Lukersmith et al., 2016).

The National Association of Social Workers (NASW) maintains that the primary purpose of case management “is to optimize client functioning and well-being by providing and coordinating high-quality services, in the most effective and efficient manner possible, to individuals with multiple complex needs” (NASW, 2013, p. 17). Within the social service context, case managers often focus on linking or “referring” individuals to resources or other needed services (i.e. SNAP benefits, healthcare, housing, etc.) and/or assisting individuals in

developing and accomplishing specific goals around essential areas of wellbeing (Aviles & Helfrich, 2004; Bender et al., 2015a; NASW, 2013).

In large part, the concept of “case management” was developed for and has been provided to adults, who either seek out case management voluntarily or are mandated to engage in case management. The traditional case management framework, including how services are provided by a case manager, is aligned developmentally, more with adults who often have invested interest in receiving these services (i.e. employment training, housing connection, parenting education, etc.) and are capable of and/or want to follow through on the goals they develop and the solutions offered by their case managers (i.e. applying for section 8 housing). Case management with youth experiencing homelessness is different. The literature outlining the experiences and needs of youth experiencing homelessness (ACF, 2016; Coates & McKenzie-Mohr, 2010; Rabinovitz et al., 2010; Thompson et al., 2010), including their developmental stage (Davis, 2003; Steinberg 2014) and history of complex trauma (Bender et al., 2014; Courtois & Ford, 2013; Herman, 1992), leads me to conclude that the traditional case management philosophy and model, developed for adults, needs to be reconsidered in meeting the unique needs of youth experiencing homelessness.

Challenges of Case Management for Youth Experiencing Homelessness

NASW’s conceptualization of case management highlighted above is a strong foundation on which to develop a trauma-informed case management toolkit for youth experiencing homelessness. Depending on the context in which a case manager is providing services to a young person experiencing homelessness, “case management” could include: outreach and referrals, connection to public and community-based resources, assistance in coordinating services, family reunification, safety planning, crisis intervention, job readiness and training,

housing navigation and life skills development (ACF, 2016; Aviles & Helfrich, 2004; Thompson et al., 2006). Research indicates that case management can be effective in helping to address several of the critical issues specifically impacting youth experiencing homelessness including, mental health and emotional distress, substance use, commercial sexual exploitation, unemployment and housing instability (ACF, 2016; Bender et al., 2015a; Ferguson, 2007; McGrew & Danner, 2009; Slesnick et al., 2008; Thompson et al., 2010). One study that examined youth experiencing homelessness utilizing drop-in centers, found that youth who engaged in case management services experienced improvements in their mental health and substance use as well as housing stability (Slesnick et al., 2008). In addition to addressing the specific issues that youth experiencing homelessness experience, case management can be effectively used in addressing the impairments and deficits caused by complex trauma (i.e. affect and behavior regulation, self-concept, etc.) that often trigger and/or exacerbate these issues (i.e. mental health, substance use, etc.), ultimately trapping young people in the cycle of homelessness (Blaustein & Kinniburgh, 2010; Cook et al., 2003).

For example, with regards to substance use, case managers can provide young people a safe space to explore/discuss/reflect on their use (i.e. why they use, how they feel when using, the consequences of using, etc.). They can help young people develop a plan to reduce their use or use in a manner that reduces risk and harm and/or link the young person to substance abuse treatment and other resources that might assist them. In addition, by helping young people address or even begin to address their substance use, case managers can help to rectify impairments caused by complex trauma, such as attachment behavior and emotional regulation, through building a mutual and trusting relationship and exploring alternative ways of regulating emotions. In helping young people to address and possibly overcome their substance use, the

case manager begins to help them remove a barrier in transitioning out of homelessness (their substance use) and ultimately helps to improve their overall health and wellbeing.

As mentioned earlier, the understanding and sensitivity to the stages of youth development, often referred in literature to “adolescent development”, is central when working with youth experiencing homelessness, particularly as it relates to providing case management services (Blaustein & Kinniburgh, 2010, Davis, 2003; Steinberg, 2014). Maryann Davis (2003) states, “The provision of services [for youth] can be affected by developmental characteristics that include distrusting authority, experimentation, social immaturity, sexual maturation and needing to fit in with peers” (p. 497). Davis reminds case managers working with youth that much of their presentation, behaviors, thought processes and decisions correlate with their developmental stage in life which makes understanding normative youth development essential for case managers (Arnold et al., 2007; Davis, 2003). In recognizing and appreciating a young person’s developmental stage, case managers learn that unlike adults, youth might not have the capability or interest in setting goals and following through on those goals. They might not value or have the ability to plan for the future. Youth might not understand the importance of becoming connected to resources, like substance abuse treatment or shelter often a key aspect of traditional case management services. (Davis, 2003, Rosado, 2000).

Adding a level of complexity to providing case management services to youth experiencing homelessness is complex trauma. As highlighted extensively in an earlier chapter, complex trauma significantly impacts the normative development of a young person, resulting in impairments in functioning and deficits in essential competencies, such as problem solving and critical thinking, competencies directly related to following through on case management tasks (Blaustein & Kinniburgh, 2010; Cook et al., 2003). For example, a young person who is

chronologically 19 years old, developmentally might be more like a 10-year-old due to the experience of complex trauma. Thus, interacting with this young person as if they are developmentally 19 years old, expecting them to have certain developmental skills when those skills have likely been compromised, could be frustrating for both the young person and the case manager. This frustration can lead the young person to disengage in case management services often interpreted by the case manager as the young person's disinterest or resistance to services. This misinterpretation, can then lead the case manager to feel rejected, frustrated or angry, which could possibly influence their willingness to continue to work with and provide needed services to the youth.

Strengths Based Case Management Model

The development of a trauma-informed case management toolkit for youth experiencing homelessness will rely heavily on Charles Rapp's (1998) "strengths-based case management" model. Rapp's strengths-based case management is a form of case management that intentionally assesses and capitalizes on an individual's strengths, prioritizes self-determination and inherently believes that individuals can "learn, grow and change" (Rapp 1998). Research suggests that strengths based case management positively influences social functioning, while reducing adverse behaviors and symptoms in vulnerable adult populations (Arnold et al., 2007; Rapp, 1998) and with some modification has been specifically shown to be effective with youth experiencing homelessness (Arnold et al., 2007).

Rapp's strengths-based case management model, aligns well with the principles of trauma-informed care, making it an ideal model of case management to incorporate with young people experiencing homelessness (Hopper et al., 2010; SAMHSA, 2014). Arnold et al. (2007) states, "strengths based case management is not simply making referrals for needed services and

waiting for a call from the client if services are not received. Case managers in strengths-based case management must get to know the persons with whom they are working and engage them in a collaborative effort aimed toward accomplishing their goals” (p. 87). As a case manager working with young people, I have found Arnold and colleagues description of case management (highlighted above) to be the most effective and meaningful in working with young people experiencing homelessness. Case management that values relationship and collaboration with young people, is the inspiration for the case management practice this project ultimately seeks to create and encourage within the field of youth experiencing homelessness services.

Charles Rapp’s (1998) strengths based case management is based on the following six principles: *1.) the focus is on the individual strengths rather than pathology 2.) the community is viewed as an oasis of resources 3.) interventions are based on client self-determination 4.) the case manager-client relationship is primary and essential 5.) aggressive outreach is the preferred mode of intervention and 6.) people can learn, grow and change* (Rapp, 1998). Rapp’s strengths base case management principles are intentional, as each is meant to enhance case management services such as connection to resources, life skills development and creating and following through on goals (Brun & Rapp, 2001). It should be noted that the principles of strengths based case management are embedded into many aspects of youth engagement best practices highlighted earlier (i.e. youth-centered and strengths-based, harm reduction, trauma-informed care and cultural humility) making it relevant to apply in working with young people experiencing homelessness.

The hallmark of Rapp’s strengths-based case management model, is that it assesses and capitalizes on an individual young person’s strengths (Rapp, 1998). In explaining strengths based case management Brun and Rapp (2001) state, “goal identification and development of a

treatment plan, led by the individuals' perceptions of what *they* need, serve as the blueprint for the work that follows. The specific activities used to accomplish these activities are flexible, tailored to meet the needs and strengths of individuals" (p. 280). In strengths based case management, case managers are encouraged to assist young people in identifying personal strengths and then leveraging and/or incorporating those strengths (i.e. their skills, competencies and talents) to assist them in accomplishing their identified goals (Rapp, 1998). In addition to valuing and capitalizing on a young person's individual strengths, strengths based case management also recognizes and taps into the environmental strengths of the young person (Rapp, 1998).

The focus on "client self-determination", or as Rapp (1998) asserts, "the belief that it is a client's right to determine the form, direction and substance of the case management help she is to receive," is a unique aspect of strengths based case management and one that is critical in working with young people experiencing homelessness (p. 50). Allowing young people to self-determine case management, particularly developing their own goals (with assistance and guidance from their case manager) is especially important for youth experiencing homelessness, as their experience of complex trauma often has rendered them helpless and without choices (Courtois & Ford, 2013; Herman, 1992; McManus & Thompson, 2008).

As a case manager, I have found that by encouraging young people like Lucia, to set their own goals, thus allowing them to determine what is important for them to accomplish at any given time, serves multiple purposes. First, self-determination allows young people to be the expert on themselves, identifying and expressing what they need and believe is important to them at any given moment. This can be empowering for young people who have often in the past been told what is best for them by their parents/guardians, social workers and various

systems such as child welfare. Second, self-determination within case management encourages young people to be equal participants within the case management process. Case management is not just something that is done to or for youth but rather is done *with* youth. Young people are encouraged to collaborate with their case manager to access the services they need to accomplish their goals. Lastly, self-determination, particularly allowing young people to decide, with the guidance of their case managers, what goals they may want to work on in case management, helps them to build their competencies around self-reflection, critical thinking, problem solving and communication. These competencies are critically important to daily functioning and positive wellbeing, and are often not fully developed due to a young person's experience of complex trauma (Blaustein & Kinniburgh, 2010; Cook et al., 2003).

As mentioned earlier, young people's complex trauma history and their developmental stage in life can significantly impact case management, especially as it relates to self-determination. Complexly traumatized youth often have difficulty in identifying and/or expressing their needs and thus they may struggle to develop case management goals on their own (Blaustein & Kinniburgh, 2010; Cook et al., 2003). Furthermore, young people's developmental stage can also influence their perception of themselves- what is important to them and/or how realistic a specific goal may be for them to accomplish (Blaustein & Kinniburgh, 2010; Davis, 2003). These realities require case managers utilizing a youth-centered, strengths based approach within case management, which encourages self-determination, to take an active role in processing, guiding and collaborating with young people. I have done this by guiding young people through a set of reflections and questions, as well as, helping them to tease out smaller more manageable goals, that will help them achieve the larger goal, that at times can feel unrealistic. Regardless of my tactics as a case manager, I have found it imperative to illustrate to

young people, both in words and actions, that I believe in them and their ability to accomplish their goals, both big and small. Over the years, I have worked with countless young people who have stated that no one ever believed in them, reinforcing the restorative power that we have as case managers when we truly believe in the young people with whom we work.

In encouraging young people to self-determine within case management, we as case managers must be willing to redefine what we conceptualize a case management goal to be in the first place. I have worked with many young people who create goals for themselves that on the surface may seem unrelated to transitioning out of homelessness, such as learning to draw, taking a dance class or playing basketball with their friends. However, these goals often enhance a young person's social wellbeing as well as develop critical life skills, that often have been impaired by complex trauma. Following through on a goal such as taking a dance or drawing class can provide young people a safe place to express themselves, allow them to explore their interests, thus helping them to identify a possible passion of theirs, participate in something they enjoy and develop life skills such as following through on a commitment and managing their time. Furthermore, it might be one less hour a week a young person is on the street. The positive outcomes from a young person following through on a goal such as taking a dance or drawing class, ultimately can impact a young person's sense of self, illustrating to them that they can follow through and accomplish a goal they set. This could lead them to believe that they can follow through on other goals, more directly connected to transitioning out of homelessness such as obtaining stable employment, following through on substance abuse treatment or securing safe and stable housing.

The most valuable aspect of the strengths-based case management model, particularly as it relates to youth experiencing homelessness, is the critical importance the model places on the

relationship between the case manager and the youth (Rapp, 1998). Rapp (1998) maintains that within case management, “the case manager-client [youth] relationship is primary and essential” (p.52), thus reinforcing the widely-held belief among youth homelessness service providers and activists that it is relationships that ultimately help to end youth homelessness. The relationship developed between the case manager and the young person provides the context and/or space to engage the young person in various case management tasks (i.e. job searching, safety planning, life skills development, etc.) (Rapp, 1998). In explaining the important role that relationship plays within case management, Rapp (1998) writes, “as confidence in the relationship replaces skepticism, the client [youth] becomes reaffirmed as a person with assets and valid aspirations, goals become more ambitious, communication more honest, and assistance more accessible” (p. 52). Rapp’s statement is profound, as it captures exactly what occurs when we, as case managers, make the relationship with a young person “primary and essential”.

The development of a safe and trusting relationship, one in which the young person feels respected, affirmed, cared for and empowered, lays the foundation for all case management work with youth (Herman, 1992; Rapp, 1998). For young people who have experienced complex trauma, establishing and sustaining safety, particularly in the context of the relationship between the case manager and the young person, is the top priority (Bloom, 2013; Courtois & Ford, 2013, Herman, 1992). In my own experience as a case manager, I have found that my connection with young people is central to them engaging with me and more importantly fully engaging in case management services such as, meeting with me regularly, following through on their case plan goals and allowing me, as their case manager, to assist and/or support them as they work towards accomplishing those goals. In reflecting on my work with Lucia, there is no question that our strong relationship greatly helped within case management. It allowed for her to trust me and

accept my assistance. It encouraged and supported her in developing and accomplishing her goals, which in turn helped her gain self-confidence and belief in herself.

In tandem to assisting young people with their specific case management goals (i.e. obtaining part-time employment, creating healthy boundaries with family, etc.), we as case managers must be intentional in strengthening and enhancing our relationships with young people. As case managers, we should use every single opportunity we have to strengthen and enhance our connection with each young person with whom we work. For example, while helping Lucia search for an apartment, we engaged in conversation about her childhood and her future. We also talked extensively about budgeting her money and various ways she can stick to her budget. We listened to music and got milkshakes. We connected and through our connection I helped her further develop her skills and build her own competencies.

Most importantly, the development of a safe and positive relationship between young people and their case managers, is in-itself a case management service. The mere willingness and ability for a young person, like Lucia, who has experienced complex trauma, including broken attachments and violations of trust, to develop a relationship with her case manager, is restorative for her (Courtois & Ford, 2013; Herman, 1992). The relationship that Lucia and I developed together allowed her to experience a connection that was based on safety, trust, respect and compassion. It was consistent and reliable. It was a relationship that focused on her needs, her development, her goals, her challenges, her successes. In being in a safe and positive relationship with their case managers, youth, like Lucia, also develop and enhance their own relational skills and competencies (Jordan, 2010). The development of these skills and competencies are important, as they help to restore some of the functioning impairments of

complex trauma and are helpful for young people to have in all areas of their life moving forward (Blaustein & Kinniburgh, 2010; Cook et al., 2003).

Case Management: A Paradigm Shift

It is important for case managers working with youth experiencing homelessness to link them with resources, assist them with problem solving, and help them set goals, however case management services for youth experiencing homelessness must expand beyond these areas. Case management services for youth experiencing homelessness must first focus on establishing and sustaining safety for the young person through building a safe and positive relationship (Courtois & Ford, 2013; Herman, 1992; Rapp, 1998). In conjunction with addressing the many critical issues that youth experiencing homelessness face (i.e. mental health, substance use, unemployment, etc.), case managers must provide interventions and services that aim to rectify the impairments and developmental deficits caused by complex trauma in the first place (Arnold et al., 2007; Courtois & Ford, 2013; Kidd & Davidson, 2007; McManus & Thompson, 2008). In my experience, the most effective and meaningful services and interventions offered by a case manager are the ones that respond to and address a youth's critical issues while at the same time aim to rectify a young person's complex trauma impairments.

As indicated in the introduction, this project encourages a paradigm shift in the way in which case management services are valued, understood and provided to youth experiencing homelessness. This shift is one in which the relationship developed between the young person and their case manager is the foundation for all other work. Thus, the relationship and the steps necessary to cultivate and sustain such a relationship, such as allowing the young person and case manager time and space to genuinely connect, must be recognized, valued and protected. The relationship that Lucia and I developed, the one that helped to facilitate Lucia's healing and

transformation, did not just happen overnight, it took time, lots of time. My approach to case management, along with the support of the agency to implement services in this way (taking into account Lucia's developmental stage and experience of complex trauma) was imperative to the successful outcomes Lucia experienced. Lucia and I spent countless case management sessions watching youtube videos together and decorating her weekly schedule (an actual calendar we created to help her better manage her time). While these activities might not be considered relevant, helpful or "billable hours", they were critical to developing a relationship that was safe and genuine.

An approach that centers around connection between the case manager and the youth, understands that case management is not just linking a young person to health insurance, helping them get into a housing program, or assisting them in finding employment. For youth experiencing homelessness, case management is anything that helps to deepen the connection with young people, develop their skills and capacities, build their resiliency and enhance their wellness and social wellbeing. For youth experiencing homelessness "case management" is helping them budget their food stamps, role modeling healthy boundaries, helping them make a doctor's appointment and then accompanying them to that appointment, teaching them how to take the bus, helping them learn to cook or do laundry, making a Halloween costume with them, listening to their frustrations and dreams and engaging them in dialogue about the choices they have made and the choices they can make in the future. All of this, regardless of how insignificant it may seem, in the end promotes connection, healing and transformation, thus helping young people to transition out of experiencing homelessness.

Trauma Informed Care with Youth Experiencing Homelessness

The development and practice of trauma-informed care is a direct response to the most important need young people experiencing homelessness have: **safety** (Bender et al., 2014; Coates & McKenzie-Mohr, 2010; Courtois & Ford, 2013; Hopper et al., 2010; Herman, 1992; McKenzie-Mohr et al., 2012; SAMHSA, 2014). All too often, I meet young people who report that they have never felt safe or tell me they cannot remember the last time they really felt safe. For young people who have experienced complex trauma, establishing safety, in every sense- physical, emotional, mental, social and spiritual- is essential, for the experience of trauma, especially complex trauma, violates their most basic sense of safety (Bloom, 1999; Courtois & Ford, 2013; Herman, 1992; Hopper et al., 2010).

As detailed earlier, the experience of complex trauma has a profound and lasting impact on a young person's development and social wellbeing. Dr. Sandra Bloom (1999), an expert in the field of trauma studies, asserts, "a traumatic experience [or multiple and concurrent traumatic experiences] impacts the entire person- the way we think, the way we learn, the way we remember things, the way we feel about ourselves, the way we feel about other people, and the way we make sense of the world" (p.1). In short, the experiences of trauma permeate every aspect of young people's lives, from altering their brain development, to influencing their emotional state, judgement, sense of self and behavior, to placing them at increased risk for physical and mental health issues (Bloom, 1999; Cook et al., 2003; Courtois & Ford, 2013; Felitti et al., 1998; Herman, 1992). In working with youth experiencing homelessness, we must use a comprehensive and holistic approach that recognizes, understands, honors and responds to the deep inhumanity of complex trauma and the consequences it has rendered on young people (Bender et al., 2014; Courtois & Ford, 2013; Fallot & Harris, 2009; Herman, 1992). For many

service providers, trauma researchers and social activists, this comprehensive, holistic approach is **Trauma-Informed Care** (Coates & McKenzie-Mohr, 2010; Fallot & Harris, 2009; Hopper et al., 2010; McKenzie-Mohr et al., 2012; SAMHSA, 2014)

What is Trauma-Informed Care?

The experience of trauma, particularly complex trauma, violates a young person's sense of safety and basic trust, rendering them helpless and leaving them feeling ashamed, isolated, disempowered and terrorized (Courtois & Ford, 2013; Herman, 1992). It takes away their choices and their voice (Courtois & Ford, 2013; Herman 1992). Trauma-informed care, sets out to intentionally restore what trauma takes from youth: safety, trust, control, choice, voice and power (Courtois & Ford, 2013; Herman 1992; Hopper et al., 2010; SAMHSA, 2014).

As stated earlier, trauma-informed care is a framework in which to interact and provide services and support to trauma survivors (Hopper et al., 2010; SAMHSA, 2014). A trauma-informed approach considers a young person's past and current trauma experiences and is sensitive and responsive to those experiences (Hopper et al., 2010; SAMHSA, 2014). In addition, a trauma-informed approach seeks to eliminate re-traumatization for the trauma survivor, particularly within the context of service provision, such as within housing programs or case management services (Hopper et al., 2010; SAMHSA, 2014). Rather than asking a trauma survivor "*what's wrong with you?*", which often blames and shames the individual trauma survivor, a trauma-informed approach asks the survivor "*what happened to you?*" (Bloom, 1994, p. 476; Bloom, 2016). In asking/reflecting on the question "what happened to you", trauma-informed practitioners aim to lessen the shame and stigma associated with trauma, and recognize and honor the multifaceted impact that trauma has on survivors (Bloom, 1994; Courtois & Ford, 2013; Herman, 1992).

The practice of trauma-informed care with youth experiencing homelessness within the sphere of case management, can help young people feel safe and can ultimately help to promote connection, healing and transformation (Bender et al., 2014; Hopper et al., 2010; SAMHSA, 2014). The advantage of trauma-informed care is that it is a holistic and transformative approach that can be used to enhance resiliency and wellness, not just for youth experiencing homelessness but for case managers working with youth (Hopper et al., 2010; SAMHSA, 2014). Hopper et al. (2010) captures the essence of this holistic and transformative approach for both youth and case managers, stating that trauma-informed care is a “*strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers [case managers] and survivors [youth experiencing homelessness], and that creates opportunities for survivors to rebuild a sense of control and empowerment*” (p.82). This project builds upon Hopper et al.’s (2010) conceptualization of trauma-informed care, expanding the approach beyond the individual trauma survivor (youth) to the promotion of wellness and resiliency of the case manager as well.

SAMHSA (2014) maintains “A program, organization, or system that is trauma-informed **realizes** the widespread impact of trauma and understands potential paths for recovery; **recognizes** the signs and symptoms of trauma in clients, families, staff and others involved with the system; and **responds** by fully integrating knowledge about trauma into policies, procedures, and practices and seeks to actively **resist re-traumatization**” (SAMSHA, 2014). SAMHSA outlines six essential principles of trauma-informed care: 1.) *safety*, 2.) *trustworthiness and transparency*, 3.) *peer support*, 4.) *collaboration and mutuality*, 5.) *empowerment, voice and choice* and 6.) *cultural, historical and gender issues* (SAMHSA, 2014). These principles help to

provide a foundation for the development and implementation of trauma informed care in interventions, services, programs and organizations and can guide service providers, including case managers in their own trauma-informed practice.

While the basic principles of trauma-informed care are constant and lay the foundation for its practice, the actual implementation is flexible depending on the context, the young person and the case manager's own personal and professional skill set and attitudes. What I offer in the section below is a practice of trauma-informed care with youth experiencing homelessness informed by the literature and my own practice experience as a case manager. It is an understanding and practice that is rooted in establishing and sustaining safety through building healthy positive relationships between myself and youth. It should be noted that the examples I provide are condensed and simplified to highlight a specific concept or area of practice and thus often do not tell the whole story or intervention with the young person in addressing a specific issue or concern. In addition, it is important to realize that we, as case managers, do not necessarily need to know the trauma history of a young person we are working with to safely and effectively engage with them. In working with youth experiencing homelessness, we should always assume that the young person has experienced trauma (remember, homelessness itself is a form of trauma) and thus utilize a trauma-informed approach regardless of any specific knowledge that we may have about the young person's past trauma experience.

Application of Trauma-Informed Care with Youth Experiencing Homelessness

I began working with Berlyn, a 18-year-old trans female, with a larger than life personality, shortly after she arrived at the youth shelter. She had missed our first two case management sessions because she was sleeping. When we finally met, I was excited and welcomed her, stating how glad I was that she was able to make it to our meeting. Berlyn,

smiled and said, “yeah I know I missed like two other meetings with you, but I was just so tired and it’s hella safe there” (referencing the youth shelter where she was staying). I smiled at her and expressed how glad I was that she felt safe at the shelter and was able to get some good rest.

Providing Berlyn a safe place to sleep and not judging or shaming her for taking time to rest, was the first step in establishing safety for her. In addition, while at the shelter, Berlyn experienced safety, through the provision of basic needs, such as food and clothing, through the healthy and positive relationships she developed with staff, including myself, and her ability to express her “trans-ness” in the space without fear of discrimination, harassment or violence. Berlyn and the countless other young people we work with daily remind us that establishing and sustaining safety must be our top priority. Safety must be embedded into all our interactions and the services we provide including, housing, crisis intervention, referrals, intakes, case planning, life skills groups, safety planning, job search outings, enrichment activities, etc. (Bender et al., 2014; Herman, 1992; SAMHSA, 2014). For it is the restoration and enhancement of safety in all spheres of a young person’s life, that allow them to connect, heal and thus transform their lives, and hopefully transition out of experiencing homelessness.

From early on in our relationship, Berlyn and I connected. We bonded over our love of hair and voguing (a form of dance). I even (very badly) tried to show her some of my favorite vogue poses. She of course responded by telling me what I was doing wrong and proceeded to teach me the “correct” way to vogue. As she began to trust me, I quickly learned that in her short life, Berlyn had been through an unspeakable amount of trauma and violence, including being victimized and targeted because of her gender identity, witnessing and participating in intense community violence and gang activity and being commercially sexually exploited by her “boyfriend”.

The application of specific principles of trauma-informed care: *trustworthiness, transparency, collaboration, empowerment, choice, voice, support and, cultural competence* can take place in all our interactions with young people. Infusing these principles into our work with young people plays an essential role in enhancing connection, healing and transformation. It does not matter if we are chatting about the latest Beyoncé album or developing a monthly budget, we can and must find ways to incorporate these principles, thus further enhancing safety for youth. For example, in chatting about Beyoncé, we can allow for and encourage a young person to form their own opinion about a particular song or video, making space for youth to voice their opinion without fear of being degraded or ignored, like so many have experienced over the years, often by their parents/caretakers. In helping youth develop money management skills we can empower them to choose for themselves what they believe is important to include in their monthly budget, how much they would like to spend on food or clothes or give to their friends and families without judging or shaming their choices which would likely re-traumatize them. In applying the trauma-informed principles to our interactions with young people, no matter how small or seemingly insignificant, we are working to create safety for the young person. We are restoring what complex trauma, has robbed them of: safety, trust, choice, voice, empowerment and unconditional support.

Trauma Lens

In applying trauma-informed care, the use of a “trauma lens” or placing a young person’s presentation, thought processes and behaviors into the context of the complex trauma they have experienced, is essential in working with young people experiencing homelessness (Cook et al., 2003; Courtois & Ford, 2013). In many ways, the use of a trauma lens is the essence of trauma-informed care. A trauma lens helps us, as case managers, to understand and respond to youth in

a manner that is sensitive to their experience of past trauma and in a way that decreases re-traumatization within service provision (i.e. case management, therapy, housing, etc.) (SAMHSA, 2014). Case managers apply a trauma lens by being aware of and sensitive to youth's specific "triggers", anticipating possible challenges youth might encounter as a result of complex trauma, helping youth to proactively address those challenges/trauma responses and developing and maintaining healthy and safe boundaries with them (Cook et al., 2003; SAMHSA, 2014). It is important to note that the utilization of a trauma lens applies not only to our individual encounters with youth but to the processes and protocols our programs and agencies develop, as these processes and protocols can most certainly re-traumatize youth.

Behaviors that on the surface might be viewed as defiance or resistance, such as youth refusing to do their chore at the shelter, when viewed through a trauma lens, might in fact be more accurately understood as a consequence of the complex trauma they have experienced (Blaustein & Kinniburgh, 2010; Cook et al., 2003). In using a trauma lens, we come to understand youth's refusal to do their chore might in fact be related to their lack the knowledge about how to do the chore or their difficulty concentrating on a specific task, both related to functioning impairments of complex trauma (Cook et al., 2003; Blaustein & Kinniburgh, 2010). In this particular situation, a trauma-informed approach encourages the case manager to reframe the youth's "defiance" or "resistance", as a trauma response and thus respond to this behavior using a trauma lens. In addressing this specific issue as trauma-informed practitioners, we might offer to assist youth in completing the chore or help model for the them the various steps in completing the chore. In addition, we might provide them written, audio or video instructions (youtube is great) on how to complete the chore. Once they do complete the chore, it is important for us to validate and praise their good work in completing it or even attempting to

complete it. It should be noted, as with many issues which we help a young people address and/or overcome, much of the actual work (i.e. teaching them how to complete their chore) can be an opportunity for us, as their case manager to strengthen our relationship with the young person.

A trauma lens can be especially helpful when viewing many of the maladaptive behaviors youth experiencing homelessness are at risk for and/or engage in such as: running away, substance use, self-harm, high risk sexual behavior and “criminality”. In viewing these behaviors through a trauma lens, we can come to see these behaviors not just as mental health, behavioral, or delinquency concerns but as likely responses to the trauma these young people have experienced (Burstow, 2003; Cook et al., 2003; Courtois & Ford, 2013; Herman, 1992). For example, it might be difficult for us, as case managers, to understand why youth “choose” to engage in sex work or why they “choose” not to have safer sex. However, if we reflect on the trauma-informed question “*what happened to you?*” as it relates to a young person who is engaging in sex work and/or not having safer sex, we might begin to better understand the “whys” of this behavior.

For youth engaging in sex work, the use of a trauma lens can help, us as case managers, to reframe a young person’s behavior and “choices”. In using a trauma lens, thus exploring the “whys” of a young person’s behavior and/or “choices”, we might come to realize that a young person’s involvement in sex work is directly linked to their experience of complex trauma experienced earlier in life (i.e. past sexual abuse and sexual exploitation), the deficits caused by complex trauma (i.e. compromised self-concept, inability to set boundaries, impairments in problem solving and critical thinking, dissociation, etc.), and/or their lack of opportunities and choices (i.e. no other source of income), often directly connected to both their experience of

trauma as well as systemic injustices, such as poverty, racism, homophobia and transphobia. Using a trauma lens when working with youth involved in sex work, allows us to better understand and respond to youth. It raises our consciousness around the “whys” of a young person’s behaviors, thus helping us to better align with the young person, which is the first step in reducing risk and enhancing safety for the young person.

In working with Berlyn, the use of a trauma lens helped me contextualize and frame many of her behaviors, allowing me to not only better understand her but also connect with her and meet her individual needs. At the youth shelter, Berlyn struggled to follow almost every rule and expectation from going to bed on time and doing her chore to following the curfew and attending school daily. When she was confronted by staff for not following a rule or expectation, she often would get an attitude, verbally lash out, or abruptly leave the shelter without permission (violating another expectation). These behaviors caused Berlyn to be labeled by shelter staff as “aggressive”, “defiant”, “disrespectful” and “rude”. However, in putting her behaviors into the context of her past trauma experience, her behaviors, while disruptive and problematic, in many ways made sense. Berlyn grew up in a home that was chaotic and dysfunctional. She never had rules or expectations. Berlyn reported that growing up, her mother didn’t care what she did, where she was, or who she was with. In short, Berlyn went from literally “running the streets” in every sense, to being in a shelter, where she felt safe, affirmed and cared for but where she had to follow rules and expectations. For Berlyn, being at the youth shelter was a completely new experience for her.

As time went on, I came to understand Berlyn’s attitude and aggressive behavior, especially when she felt challenged or threatened, as a learned survival behavior. A behavior she needed survive, physically and emotionally, while on the streets. Berlyn once mentioned to me,

backing down from a fight or confrontation was not an option in her neighborhood, as being aggressive and violent helped to keep her safe and respected, especially when she was challenged. These learned behaviors (i.e. being aggressive, cussing someone out, etc.) continued while in the shelter whenever she was confronted or felt challenged, by both other youth as well as staff. In addition, Berlyn had multiple traumatic experiences with authority figures, particularly with law enforcement, such as being verbally harassed, threatened and assaulted. These painful and humiliating experiences, perpetrated by those who were supposed to protect her, contributed to her deep fear and distrust of all those in authority including shelter staff, teachers and even myself, and sometimes contributed to her attitude and “defiance” of staff.

One of the main purposes of trauma-informed care is to eliminate incidences of re-traumatization for trauma survivors, particularly within the context of service provision (Hopper et al., 2010; SAMHSA, 2014). In implementation, this could mean not asking youth to tell “their story” of trauma multiple times or even at all just to access services. It could mean ensuring that services are provided to all youth in a “low-barrier” fashion (i.e. services and support without strings attached). It could mean maintaining a physical space that is free of substances, discrimination, harassment and violence. Or it could mean that all staff are competent, supportive and caring. Staff competency, especially around complex trauma and its impact, is extremely critical, as it can assist staff in engaging with youth in a manner that honors the youth’s experience of trauma and significantly lessens the likelihood of re-traumatization by individual staff comments and/or actions (Salloum, Kondrat, Johnco & Olsen, 2015).

In many ways honoring trauma-informed care’s goal of eliminating the re-traumatization of young people seeking support and services relies heavily on the use of a trauma lens. The use of a trauma lens can be particularly helpful in accomplishing this purpose, as it can help case

managers examine how their language, actions, processes and protocols could trigger and re-traumatize young people seeking services and support (Fallot & Harris, 2009; SAMHSA, 2014). For example, I once worked in a drop-in space that withheld resources such as food, hygiene supplies, and bus passes if youth did not fully participate in the program, which included attending psycho-educational groups. This policy and others that withhold or limit services and resources for youth (especially basic needs such as food) unless the youth “fully participate” in the program (however that is defined) can be extremely traumatizing for young people. In fact, withholding services and resources in order to get young people to do things, such as attend a group, mirrors many of the unhealthy, manipulative and abusive dynamics youth have experienced in the past (i.e. neglect, victimization and exploitation). In developing and enforcing these policies and procedures, we as service providers, assert authority and control over young people, much like those that have abused, victimized and exploited them, thus further inflicting trauma onto youth (Courtois & Ford, 2013; Herman, 1992; Thompson et al., 2006).

Curiosity

Along with using a trauma lens, the practice of curiosity can be extremely helpful in applying trauma-informed care with young people experiencing homelessness (Briere & Lanktree, 2013). In fact, curiosity, that is the genuine and respectful interest in truly understanding a young person’s experience, presentation, feelings and behavior, is at the center of trauma-informed care’s fundamental question: “*what happened to you?*”. As trauma-informed practitioners we ask/reflect on this question, not because we want to pry into the trauma histories of young people, but rather to recognize, honor and begin to understand a young person’s past experiences and how those experiences have shaped their interactions, their feelings, their behaviors and their sense of self (Briere & Lanktree, 2013).

As a case manager, I have found that being “curious” about a young person’s presentation, thought processes and/or behaviors helps me to better understand a young person and thus connect with them, assist them and advocate for them. Being curious about the youth I work with has led me to wonder: why a young person might not want to go to bed or why he can’t make eye contact with me or why she keeps going back to her pimp or why he is always avoiding therapy or why she leaves the shelter to get high. In these situations, and so many more, it is easy to focus on a young person’s presentation or behavior and label them “oppositional”, “defiant”, “disrespectful”, “borderline”, “substance dependent” or “deserving of the consequences”. However, in my experience working with youth engaging in these behaviors and many other “problematic” behaviors, being curious about these situations and why a young person might be conducting themselves in a specific manner or behaving in a particular way has been much more beneficial in our work together.

Being curious about a particular young person’s presentation or behavior, gives me time to think and reflect about that particular young person, what has “happened to her?” and how what has happened to her might be contributing to her current issue or concern. In working with Berlyn, one such issue was her attendance at school, in which she either flat out refused to go or would leave for school in the morning but never actually arrive there. One day, after much encouragement and convincing by shelter staff, Berlyn went to school, only to be sent home a few hours later for cussing out a teacher. I, along with the rest of the staff were frustrated and annoyed, both with Berlyn and the situation in general. Out of frustration, some staff advocated for Berlyn to be exited from the shelter, as she was not regularly attending school, a requirement to stay in the shelter.

When I met with Berlyn to talk about the situation, I knew that she had already been lectured and somewhat shamed by another staff, so instead of coming from a place of frustration and disappointment (which I was), I made the conscious decision to engage with her from a place of curiosity. I wanted to come from a place of really trying to understand what was going on with her and why she had been engaging in these behaviors, in an effort to both connect with her as well as help to address the real issue. In talking with Berlyn I let her know that I had noticed that she hadn't been going to school regularly and explained to her how important it was for her to continue going to school. I also reminded her that she chose her school and up until a few weeks ago, she seemed to like going to school.

Berlyn then shared with me that she was still involved with her "boyfriend"/pimp and that he had found out where her school was and was often hanging around the school waiting for her. She shared that she was afraid if she saw him or he found her that she wouldn't be able to say no to him when he asked/forced her to come with him. As she told me this, I realized that her behavior was not about not wanting to go to school, it was about not knowing how to set boundaries with someone, it was about protecting herself the only way she knew how, it was about survival. If I had not come from a place of genuine curiosity as well as openness (which had been part of our relationship all along) Berlyn might never have felt comfortable enough to share with me what was really going on. She might have been labeled "defiant" and possibly exited from the shelter for not "following the rules". However, that is not what happened. I was curious about the "why" and she trusted me enough to tell me the "why" and then we worked together to develop a plan to address the "why".

Trauma-Informed Consequences

Because trauma-informed practice aims to respond to the specific experiences and needs of an individual young person and often is embedded into the relationship developed between the young person and the case manager, it can be easily misunderstood as lacking accountability and consistency. In my experience, the most common misconceptions of trauma-informed care is that it “allows youth to do whatever they want” and “makes excuses for youth’s behaviors”. It should be noted that both these misconceptions are framed from a “*what is wrong with you?*” perspective, rather than a “*what has happened to you?*” perspective, thus setting up a negative view of trauma-informed care in the first place. For individuals who may not use a holistic strengths-based trauma-informed framework in engaging with young people, it is easy to misunderstand trauma-informed practice as lacking “accountability”, “allowing youth to do whatever they want” or “making excuses for youth”.

In large part, the practice of trauma-informed care and its framework runs counter to our cultural norms, attitudes and social systems that value a pathology-based, punitive and retributive approach in addressing problems. Asking “what has happened to you?”, rather than “what is wrong with you?” is a paradigm shift (Bloom, 1994; Hopper et al., 2010). With that paradigm shift comes a more strengths-based, restorative approach, that focuses on understanding the “why” of a youth’s behavior, thought processes and presentation and then using the “why” to inform the responses to that youth. These responses, often called interventions within service provision should foster connection, promote healing and encourage growth, rather than shame, stigmatize and punish young people, which is re-traumatizing.

Within a trauma-informed practice, our responses for holding youth “accountable” for “problematic” behavior, is what is known as “trauma-informed consequences” (Schnier et al., 2009). Trauma-informed consequences are responses, often to “problematic” behavior (i.e.

violation of shelter rules or expectations, not following through on case plan, etc.) born out of a trauma-informed practice paradigm shift, in which youth are held “accountable” in a way that is supportive, intentional and encourages healing and growth (Schnier et al., 2009). These consequences are often created in collaboration with the young person and are relevant/directly linked to the situation/problem being addressed.

In my experience, utilizing trauma-informed consequences enhances our relationship with youth and allows them to truly reflect and learn from whatever behavior or situation they are being held “accountable” for in the moment. For instance, for young people who do not follow through on their case plan goal of obtaining a part-time job, I often will explore and process with the youth why they have not been able to follow through on this goal. In these conversations, I align myself with the youth, often recognizing the positive steps they have taken (however small) in trying to follow through on this goal. I also make clear to them that they can accomplish this goal and reiterate my willingness to assist them in any way they might feel is helpful (i.e. resume writing, mock interviewing, taking them job searching, etc.). In my experience, the therapeutic alliance/relationship I have developed with the young person, prior to these situations/conversations allows them to feel comfortable and safe enough to be vulnerable and share with me some of the reason’s (i.e. barriers/challenges) they are experiencing in following through on obtaining employment. We then, work together to develop a plan to address these barriers. If nothing else, this process creates a space for youth that is positive, hopeful and one that aims to encourage growth.

When I reflect on my own experience in utilizing trauma-informed care with young people experiencing homelessness, I think of the many times I accompanied a young person to the hospital because they were afraid and had no one else to go with them. I think of times I

would take a young person who had just gotten into a fight or verbal altercation on hike, in an effort to help them process what happened and teach them how to regulate their emotions. I think about the countless job outings I went on with the same young person who struggled to get a job. I think about visiting young people in the hospital, attending their high school graduations, organizing baby showers, attending BlackLivesMatter rallies and accompanying youth to funerals. I think about helping youth to identify and process their triggers. I think about the hours upon hours that I have spent talking with young people about hair and nails, about police brutality and racism and about going back to school and setting healthy boundaries.

Secondary Trauma and Burnout

In providing case management services to complexly traumatized young people, we as case managers, no doubt become deeply impacted by the violations of humanity that youth have survived. The impact that we, as case managers often experience, as a result of working with survivors of trauma, is referred to as secondary traumatic stress (Figley, 1995; NCTSN, 2011). Just as complex trauma impacts youth experiencing homelessness; secondary trauma can have a significant impact on case managers working with youth experiencing homelessness (Figley, 1995; NCTSN, 2011; Salloum et al., 2015; van Dernoot Lipsky, 2009). This impact can influence our ability to effectively and appropriately engage with and provide services to young people, as well as adversely influence our own physical, mental and emotional wellness, all of which can lead to burnout and impaired social wellbeing (Figley, 1995; Kidd et al., 2007; Perry, 2014; van Dernoot Lipsky, 2009). The experience of secondary trauma amongst us, as case managers and its negative consequences, makes the use of trauma-informed care all the more important (Hopper et al., 2010; NCTSN, 2011; Salloum et al., 2015).

According to Charles Figley (1995) secondary traumatic stress is “the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other- the stress resulting from helping or wanting to help a traumatized or suffering person” (p. 7). Secondary trauma occurs when an individual, such as a case manager, experiences emotional distress, which could include PTSD symptoms, due to working with trauma survivors (Figley, 1995; Perry, 2014). Figley (2002) maintains that secondary trauma is “defined as a state of tension and preoccupation with the traumatized patients [youth] by re-experiencing the traumatic events, avoidance/numbing of reminders, persistent arousal (e.g., anxiety) associated with the patient” (p. 1435). In short, working intimately with trauma survivors, particularly bearing witness to the extreme trauma youth have experienced, can traumatize case managers, leaving a lasting impact on them (Figley, 1995; Perry, 2014,).

Research indicates that individuals working with traumatized children and youth, such as case managers, are at heightened risk of developing secondary trauma and thus burnout (NCTSN, 2011; Perry, 2014; Salloum et al., 2015). Dr. Bruce Perry (2014) maintains the reasons for this heightened risk include: staff empathy (i.e. staff deeply “feeling a youth’s pain”), insufficient recovery time (i.e. staff exposed to lots of trauma with little time to process), unresolved personal trauma of staff (i.e. hearing youth’s trauma can trigger staff’s past trauma experience), children are the most vulnerable members of society (i.e. the knowledge that children/youth are especially vulnerable), staff isolation and systemic fragmentation (i.e. staff feeling alone and isolated in their work) and lack of systemic resources (i.e. the agency’s/system’s unawareness and/or unwillingness to address staff’s secondary trauma) (p. 11). Similarly, a study that specifically examined youth experiencing homelessness service providers found that factors that contributed to burnout amongst the workers were: social stigma

around homelessness, poor boundaries with youth and the extreme nature of what youth experiencing homelessness face on a daily basis (i.e. trauma, victimization, etc.) (Kidd et al., 2007).

For case managers, secondary trauma often leads to a “trauma exposure response”, which Laura van Dernoot Lipsky (2009), author of *Trauma Stewardship* states is “the transformation that takes place within us [case managers] as a result of exposure to the suffering of other living beings on the planet” (p. 41). The most common trauma exposure responses are: *inability to embrace complexity, hopelessness and helplessness, emotional exhaustion, inability to listen/avoidance, sense of persecution, hypervigilance, diminished creativity, sense one can never do enough, guilt, minimizing, fear, emotional numbing, addictions, and anger and cynicism* (van Dernoot Lipsky, 2009; NCTSN 2011). These trauma exposure responses are critical to identify and address, as all can have a deep and profound impact on case managers and the young person interacting with the case manager (van Dernoot Lipsky, 2009; NCTSN, 2011)

It should be noted that many of the trauma exposure responses that a case manager can experience as a result of secondary trauma (i.e. diminished creativity, inability to listen and embrace complexity, etc.) directly impacts our ability to fully and effectively apply a trauma-informed approach with young people (van Dernoot Lipsky, 2009; Salloum et al., 2015). For instance, I have found creativity or “thinking outside the box” to be an important part of my trauma-informed practice with youth, which makes the trauma exposure response of diminished creativity very problematic. I have found that being creative allows us, as case managers to take the principles of trauma-informed care and apply them in a manner that makes sense for the specific young person we are working with. The application of trauma-informed consequences, relies especially on our ability to be creative and “think outside the box”, when holding youth

“accountable” for not following through on an expectation. For it is creativity that often allows us to craft a consequence or growth opportunity for a youth that is meaningful and restorative. In short being creative with how we engage or develop an intervention helps us to better meet the individual needs of a young person, while also strengthening our relationship with them.

For example, one of the issues that Berlyn struggled with was being on time for school, mainly because it took her a very long time to get ready in the morning. Instead of shaming her for taking too long or telling her that she did not need to look “dope” every day and that it was just school, we sat together and figured out a plan. A plan that might not have been able to be developed I had not managed and addressed the trauma exposure responses I was susceptible to. It should be noted that as a young trans female, Berlyn’s physical presentation (i.e. her hair, make-up, clothing, etc.) was critically important to her (particularly to her physical safety), thus any plan we developed had to honor and align with this importance. After much discussion, the plan included developing a morning schedule with specific times Berlyn would do things (i.e. wake up time, 2nd wake up time, shower, hair, make up, etc.). While I assisted her in making a morning schedule and guided her with more appropriate time limits for her each activity, Berlyn put most of it together herself. Furthermore, in “thinking outside the box” we explored other ways she could cut time in the morning such as: choosing her outfit the night before, not completely changing her hair style every day and taking a different bus route that was faster.

Trauma exposure responses not only influence our ability to fully and effectively implement trauma-informed care but often can have a significant and sometimes harmful impact on youth. This was certainly the case for staff working with Berlyn, as they seemed to experience several trauma exposure responses. For insistence, I noticed that many staff struggled to recognize, understand and respond to the complexity of her life and subsequently

her complex set of beliefs and behaviors, beliefs and behaviors that were extremely challenging for staff address and thus deemed “problematic”. Staff’s inability to embrace Berlyn’s complexity (i.e. her layered experiences of trauma and the impairments it caused as well as how her identity as a black trans female influenced her life experiences and behaviors, including the reactions and treatment she received by staff, particularly in the form of micro-aggressions), led to Berlyn being misunderstood and often targeted by staff. In the end, these trauma exposure responses resulted in Berlyn, an 18-year-old, African American trans female, an individual from one of the most vulnerable and marginalized communities in society (trans women of color) to be exited from the youth shelter, just as she was beginning to make some positive changes.

In reflecting on Berlyn’s time at the shelter, I often wonder what might have been different for her if staff was able to effectively and consistently use a trauma-informed approach with her, which would require the provision of their own physical, mental and emotional safety and wellness (Hopper et al., 2010; SAMHSA, 2014). I wonder what might have been different if the staff had tools and support in dealing with their own trauma exposure responses. What would have been different if there were agency policies and practices in place to address the secondary trauma of staff. Berlyn’s exit from the shelter highlights how important addressing secondary trauma amongst staff is in the provision of trauma-informed services for youth like Berlyn. And how addressing such secondary trauma and specifically trauma exposure responses, could help to limit the possibility that youth, like Berlyn, will be restricted from services, including safe housing.

The experience of secondary trauma not only impacts the provision of quality trauma-informed services for youth but ultimately reduces our capacity and wellness, which leads to burnout (Hopper et al., 2010; Figley, 1995; Maslach, 1982; Salloum et al., 2015). Maslach

(1982) states “burnout is a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do ‘people work’ of some kind” (p.3). Conrad & Kellar-Guenther (2006) go on to state “burnout is a ‘process’ in which a previously committed professional [i.e. case manager] disengages from his or her work in response to stress and strain on the job” (p. 1073).

Burnout is often facilitated and exacerbated further by trauma exposure responses, impacting the case manager as well as the young person (Kidd et al., 2007; Salloum et al., 2015; van Dernoot Lipsky, 2009). For example, a case manager who is “burnt-out” might be easily irritable or not fully present with the youth they are working with (Conrad & Kellar-Guenther, 2006; Salloum et al., 2015). These case managers can over-react or miss critical warning signs related to a youth’s safety. Ultimately burnout leads staff, including case managers to leave the field (Conrad & Kellar-Guenther, 2006; Kidd et al., 2007; Salloum et al., 2015). In fact, the high turnover of staff (staff leaving the field), can deeply impact youth, particularly youth who have built relationships with these staff members (Kidd et al., 2007; Salloum et al., 2015; van Dernoot Lipsky, 2009).

In my experience, the hesitancy for youth to connect with staff, is not only due to their history of complex trauma, but also due to broken attachments/ relationships they have experienced with case managers and other service providers over the years. Many young people, have had several relationships with service providers who the youth have subsequently lost touch with, due to staff leaving the field, frequently due to burnout. These broken attachments and abandon relationships, often with little or no healthy closure, then become yet another form of loss and trauma a young person experiences, this time perpetrated by the service provider. While it is natural for case managers and other staff to move on from their work with youth, far too

many of us, move on as the result of secondary trauma and burnout (Kidd et al., 2007; Salloum et al., 2015). The application of trauma-informed care is a way to help mitigate the effects of secondary trauma and prevent burnout, thus enhancing our own wellness and resiliency as case managers as well as reducing the possibility that a young person's attachment with their case manager will be broken.

Application of Trauma-Informed Care for Case Managers

While much of this project is devoted to understanding, and addressing the complex trauma and thus the critical issues that youth experiencing homelessness often face, it does not ignore the impact of this work on us, as case managers. The trauma-informed approach this project prescribes to and seeks to implement is one that Hopper et al. (2010) states “emphasizes physical, psychological and emotional safety for **both** providers [case managers] and survivors [youth] (Hopper et al., 2010, p. 82). This project's commitment to case manager safety, in all areas, is an important and unique aspect of the trauma-informed toolkit, as it directly combats the secondary trauma and burnout that case managers are likely to experience, while enhancing their wellness and resiliency (Fallot & Harris, 2009; Salloum et al., 2015).

In line with a trauma-informed approach this project encourages case managers to seek out and engage in wellness and resiliency enhancing practices (Hopper et al., 2010; Salloum et al., 2015). In my experience, these wellness and resiliency enhancing practices can be helpful in addressing the effects of secondary trauma and ultimately prevent burnout (Hopper et al., 2010; Salloum et al., 2015). Chief among these practices is self-care.

In recent years, “self-care” has become a buzzword in the human service field. Self-care is an umbrella term often used to refer to individual actions that one might take to protect and enhance their own personal wellness and social wellbeing (Perry, 2014; Salloum et al., 2015).

van Dernoot Lipsky (2009) maintains that “by developing a deep sense of awareness needed to care for ourselves while caring for others and the world around us, we can greatly enhance our potential to work for change, ethically and with integrity, for generations to come” (p. 12).

Depending on the case manager, possible components of self-care could include activities that enhance the case manager’s physical, emotional, mental, communal, and/or spiritual wellness (Perry, 2014). These activities could range from engaging in physical exercise, spending time with family and friends, exploring passions such as art or cooking, engaging in mental health counseling, attending religious services, volunteering, etc. Regardless of the specific activities, a consistent self-care practice can help enhance case manager’s wellness and resiliency, which assists case manager’s in managing and mitigating the effect of secondary trauma (Salloum et al., 2015; van Dernoot Lipsky, 2009).

Along with the practice of self-care, another wellness and resiliency enhancing practice that is helpful for case managers in addressing secondary trauma and trauma exposure responses is trauma-informed supervision (Hopper et al., 2010; Kidd et al., 2007; Salloum et al., 2015). Trauma-informed supervision, that is supervision that is supportive and aligned with a trauma-informed approach can be extremely helpful for case managers working so intimately with trauma survivors (Hopper et al., 2010). This supervision creates a safe space for the case manager to process their thoughts and feelings about a particular young person or situation. It allows case managers space to explore and understand how their thoughts and feelings might have impacted their actions with a specific young person. Trauma-informed supervision pays special attention to case managers own emotional responses to youth attitudes and behaviors, as these emotional responses can often directly influence the work with youth (Salloum et al., 2015). It also allows space for the case manager and supervisor to brainstorm together

alternative interventions or ways of engaging with a particular youth in an effort to meet the specific needs of the youth.

Embedded into quality trauma-informed supervision is education and training, which can help build the skill set and capacity of the case manager (Coates & McKenzie-Mohr, 2010; Hopper et al., 2010; Salloum et al., 2015). Salloum et al. (2015), maintains “specialized trauma training has been associated with greater level of compassion satisfaction [i.e. case manager resiliency] and lower levels of compassion fatigue [i.e. secondary trauma] in mental health workers, and shows trends towards lower levels of burnout” (p. 55). Overall, good trauma-informed supervision can mitigate some of the trauma exposure responses such as diminished creativity and feelings of being overwhelmed and/or emotional exhaustion, through the application of trauma-informed principles such as, transparency, collaboration, empowerment, choice and voice (SAMHSA, 2014; van Dernoot Lipsky, 2009). Trauma-informed supervision recognizes and then responds to trauma exposure responses and secondary trauma, through providing consistent, compassionate support and technical guidance to the case manager.

The work we do as case managers, particularly the exposure we have to young people’s past and current experiences of trauma can take a major toll on us. As a case manager working with young people experiencing homelessness over the years, the only way I have found to effectively and humanely address this toll is to utilize a trauma-informed approach throughout my practice. I have found that this approach is not only necessary for youth who have survived trauma but also for us, as case managers. I have found the engagement in holistic self-care and trauma-informed supervision, along with social action (discussed in the following chapter) to be imperative in enhancing my own wellness and resiliency. Taking care of my physical, mental, emotional and spiritual self through adequate rest and relaxation, engagement in activities I

enjoy, physical exercise, spending time in nature and engaging in social justice activism all have been essential in my ability to continue to do the work with youth experiencing homelessness.

The Beauty of Trauma-Informed Care

In working with Berlyn, there were countless ways I incorporated trauma-informed principles into our relationship and thus our work together. One that stands out in my mind centers around the trauma-informed concepts of *voice, choice and empowerment*. It began when Berlyn was checking in with me one day. She shared with me that her school counselor had asked if she wanted to speak at *Trans Day of Remembrance*. I asked her if that was something she wanted to do and she responded that she did not know. We then talked a little about the purpose of *Trans Day of Remembrance* (she had never heard of it), which got her talking about various situations (all deeply painful and traumatic) she had experienced as a trans youth. Looking back now, I realize that just asking this question and explaining *Trans Day of Remembrance* helped Berlyn tap into her own voice and empowered her to share some of her experiences with me (both principles of trauma-informed care). This relatively short, seemingly insignificant interaction allowed for Berlyn to be the expert of her own life. It allowed her to decide what parts of her experience she would share with me, thus she had the control over her own story. This small conversation, unrelated to any specific “case management” goal, greatly enhanced our connection and allowed me the chance to better understand Berlyn, which in the end helped to strengthen our working relationship. While I was careful not to tell her that she should or should not participate in *Trans Day of Remembrance* (as it was important that her participation be her choice), I did encourage her to think about participating and told her that if she chose to speak at the event, she would have some powerful things to share. Berlyn smiled and said she would think about it.

A few weeks later, Berlyn told me she might, possibly, “do a little speech” at *Trans Day of Remembrance* the following day and wanted me to know that I was welcome to stop by, “if I had time,” she said. Berlyn, like many young people, did not flat out ask me to come support her nor did she share that it was important to her for me to come to support her, as she was rejected too many times before to put herself out there like that. But I knew she wanted me to come and support her and I was honored that she asked me.

The next day some youth and I went to support Berlyn at *Trans Day of Remembrance*. When we arrived, Berlyn told me that she still didn’t know if she would speak at the event or what she would even say. I reassured her that it was her choice in what she shared and anything, if she chose to speak, would be amazing. She smiled and rolled her eyes. Then five minutes later, she stepped to the stage and shared some of her experiences. Her words were authentic and from the heart. She was beyond inspiring.

I realized that this event and Berlyn’s participation in it, was transformative. Here was Berlyn, a young black trans female, whose very identity was so often misunderstood, controlled, violated and criminalized, sharing her story, a story that she chose to tell in her own words, a story that was listened to, honored and validated by her classmates and teachers. After she was finished, she came running over, with a huge smile and I told her how inspiring she was. She smiled and gave me a side hug. I thought to myself how important these moments are not just in the lives of the young people, like Berlyn, but for me, as her case manager. How lucky was I to know such a remarkable young person, how lucky was I to witness this young person, despite so much trauma and struggle, rise to speak her truth. To name herself. To bare her soul. To advocate for herself and others in her community.

While not an explicit “case management goal”, Berlyn’s participation in *Trans Day of Remembrance* is what this work is all about. It is about showing up for the youth, both physically and emotionally. It is about presenting choices. It’s about supporting them. It’s about encouraging and empowering them. It is about affirming and validating them for who they are in the moment. It is about believing in them. It is about connection, healing and transformation.

I have come to realize that practicing trauma-informed care with youth experiencing homelessness is an art form. It can be exciting, fun, emotional, confusing, challenging and messy. But in the end, it is beautiful. The beauty of trauma-informed care and our role, as case managers in applying it with young people experiencing homelessness requires us to build a relationship with young people that is safe and healing. It understands and responds to a young person’s experience of complex trauma. It respects where a young person is in the moment. It affirms and honors them for who they are. Through trauma-informed practice we, as case managers can connect with young people, help them to heal and empower them to transform their lives. And in doing this work with young people, we, as case managers also are able to better connect to ourselves and others. Through connection to ourselves and others we can participate in the transformation of ourselves and our society. For trauma-informed care is a parallel process. The connection, healing and transformation goes both ways. In practicing trauma-informed care, we recognize, honor and affirm the dignity and humanity of the youth we have the privilege to work with and through that work our own dignity and humanity is affirmed and enhanced as well.

Radical Trauma Practice and Youth Homelessness

Systemic injustices pervasive throughout society contribute significantly to youth homelessness. These injustices, particularly poverty, violence and oppression, and how they manifest within systems, institutions and policies, deeply impact young people's lives, often facilitating and/or exacerbating their experiences of trauma and injustice. As case managers working with young people daily, we know all too well the impact that these systemic injustices have on young people. We also know that all too often these systemic injustices, like racism and homophobia, influence not just a youth's opportunities, but also their sense of self, their health and overall social wellbeing. This reality requires case managers working with young people experiencing homelessness not only recognize and understand the enormous toll that systemic injustices have played in the lives of young people and address them within case management but also demands that we, as case managers, work to tackle these systemic injustices through community organizing, advocacy and social action. In short it requires a "radical trauma practice", of which there is an understanding that a young person's experience of trauma is inextricably linked with systemic injustices, thus demanding we act on both a micro and macro level to address those injustices.

Expanded Notion of Trauma and Trauma Work

Much of what has been presented thus far regarding complex trauma aligns with a more individualized conceptualization of trauma. This conceptualization focuses on the impacts and effects that trauma has on individual youth. As a case manager this more individualized, "clinical" understanding of trauma, particularly how trauma impacts a young person's development, functioning, choices, health and wellbeing, is essential to understand and address when working directly with young people (Cook et al., 2003; Courtois & Ford, 2013; Herman,

1992). However, due to the realities of youth homelessness and the systemic injustices at the root of youth homelessness itself, we must expand our conceptualization of trauma beyond the individual young person (Burstow, 2003; Coates & McKenzie-Mohr, 2010; McKenzie-Mohr et al., 2012).

In explaining this expanded and more complete conceptualization of trauma, Bonnie Burstow (2003) states “trauma occurs in layers, with each layer affecting every other layer. Current trauma is one layer. Former traumas in one’s life are more fundamental layers. Underlying one’s own individual trauma history is one’s group identity or identities and the historical trauma with which they are associated. Underpinning this are the structural oppressions and the institutions through which they operate” (p. 1309). For youth experiencing homelessness, in addition to their past and current experiences of trauma (i.e. abuse, neglect, exploitation, community violence, homelessness, etc.) it is the “structural oppressions”, racism, classism, sexism, homophobia, transphobia and xenophobia and “institutions through which they operate” such as, child welfare, public education, criminal justice, social welfare, housing, etc., that are at the root of the trauma these young people experience (Burstow, 2003; McKenzie-Mohr et al., 2012). It should be noted that trauma caused by structural oppressions, often adversely influence a young person’s mental health and ultimately facilitate, perpetuate and exacerbate further trauma these young people experience (Burstow, 2003; Smith, Chambers & Brantini, 2009).

For young people experiencing homelessness, trauma is not just an isolated incident, inflicting harm and pain on them as an individual, but is the result of larger forces within our society that oppress, marginalize and subjugate them. Burstow (2003) asserts, “The regimes of ruling [i.e. those people/institutions/values of power in society], moreover, involve and create

structures and dynamics that alienate us from the natural world, each other and ourselves and that pathologize and regulate expectable responses to alienation and injury [i.e. trauma]" (p. 1308).

For those of us working with marginalized and oppressed populations, such as youth experiencing homelessness, it is imperative that we place the traumas that young people experience and their individual and communal reactions to these traumas, into our larger social and political context (Burstow, 2003; McKenzie-Mohr et al., 2012). This requires us, as case managers, to critically examine how social and political attitudes, values and systems present throughout society, of which we often participate in and sometimes even create, have enabled, facilitated and/or enhanced the trauma these young people experience (Smith et al., 2009). One such example is our societal attitudes and policies towards substance use.

Many young people experiencing homelessness use alcohol or drugs to cope with the emotional stress of homelessness as well as numb the pain from past and current traumatic experiences (Kidd, 2004; Kidd & Davidson, 2007). Instead of viewing a young person's substance use as an "expectable response to alienation and injury" (i.e. a response to the trauma they have experienced) we, as society, through our collective attitudes, values, policies, laws and social practices, stigmatize, isolate and criminalize, not just the behavior of substance use, but the young person engaging in the behavior as well. Society's harmful, discriminatory and marginalizing approach to a young person's response in coping with and/or managing the unimaginable then becomes another form of trauma that a young person experiences. This trauma, often caused by society's collective attitudes, values and policies, is then layered on top of all their other experiences of trauma. It should be noted that many of us, as case managers, work within programs and agencies that, just like society, stigmatize, isolate and punish young people for their "expectable response to alienation and injury" (i.e. their substance use). We do

this in our individual reactions to young people's substance use, often shaming and stigmatizing them, as well as through enacting or upholding zero-tolerance policies and restricting/exiting young people from housing or services due to their substance use.

In working with youth experiencing homelessness, the role that systemic oppression plays in trauma is particularly relevant. Burstow (2003) maintains that "oppression is the primary traumatizing condition" and that oppressed groups (i.e. youth experiencing homelessness, youth of color, LGBTQ youth, etc.) likely experience greater traumatization, due to their marginalized social identities (Burstow, 2003, p.1308). Furthermore, oppression itself, based on a young person's race, ethnicity, language, ability, gender, gender identity, sexual orientation, immigration status and/or religion, can be yet another trauma a young person experiences, layering on top of other traumas they have experienced. The link between oppression and trauma is extremely important for us as case managers to be aware of and understand.

Many of the young people I have worked with over the years, particularly youth of color, undocumented youth and LGBTQ youth have shared with me deeply traumatic experiences of racism, sexism, homophobia, transphobia and other forms of oppression and subjugation. These traumatic experiences, from micro-aggressions and bullying, to harassment and violence happen to youth within their homes, their schools and their communities, by family members, teachers, social workers, neighbors, doctors, store clerks and their peers. The experience of these traumas can significantly impact young people's wellness and often deter these young people from accessing services or support (i.e. shelter, healthcare, etc.), thus further marginalizing them and placing them at risk for further victimization (Smith et al., 2009). Due to the significant role that oppression and marginalization play in the lives of young people experiencing homelessness, the

concepts of cultural humility, intersectionality and Social Justice Youth Development (explored within this chapter) are essential to a case management practice that aims to be anti-oppressive and create social change (Ginwright & Cammarota, 2002; Jones, 2016; Ortega & Faller, 2011).

In being sensitive and responsive to the lived experiences of youth experiencing homelessness, I have come to subscribe to what Bonnie Burstow (2003) has called a “radical understanding of trauma and trauma work” (Burstow, 2003, p. 1293). Burstow (2003) states, “radical trauma practice is necessarily based on an awareness of the centrality of oppression in the traumatizing of human beings, communities and the earth itself. It is also based on compassion and respect for traumatized individuals and communities [i.e. youth experiencing homelessness]: their history, their strengths, their naming, their conundrums, their choices” (p. 1310). This reimagined, expanded and “radical” understanding of trauma, moves us beyond understanding trauma as an individual issue resulting in just assessing and treating individual effects of trauma, to recognizing and addressing the systemic injustices both causing and perpetuating trauma for so many young people (Burstow, 2003, McKenzie-Mohr, 2012). For me as a case manager, the utilization of a radical trauma practice has become central to my understanding and work with young people experiencing homelessness. One such example has been my work over the years with a young African American male named Malik.

Malik was 19 years-old when I met him. He was shy, unsure of himself, overly polite and respectful. We began working together as he was transitioning out of an intensive mental health treatment program. At the time, he was eager to obtain his high school diploma and get his first job. However, after a few weeks of working together, I noticed that Malik lacked many basic life skills, had difficulty putting into words what he was thinking or feeling and was often lost in his own thoughts. In addition, he had an extreme lack of confidence in himself, which I

noticed not only through what he believed he was capable of, but how he acted and even how he carried himself physically (always hunched over and avoiding eye contact). I quickly realized that Malik had experienced significant trauma growing up, causing impairments in his cognition, emotional regulation and self-concept. Due to these impairments, he lacked many basic competencies and life skills, one would expect someone his age to possess.

I would soon learn Malik grew up homeless, spending most of his childhood living out of different motels with his mother and older sister. His mother, mentally ill and addicted to drugs, would often engage in sex work in exchange for money and/or drugs. Due to the instability of his mother and their living situation, Malik stopped going to school around the 7th grade and spent most of his days in front of the TV in whatever motel they were staying in at the time. Malik shared very little about his childhood with me and I got the sense he could not remember much of it. About year into our work together, Malik shared with me that he was sexually abused as a young child (which was the first time he had identified and shared this memory with anyone). While Malik spoke with affection about his family, he grew up being told by his mother that he was “stupid” and “dumb”, and that he would “end up just like his father”. Malik never met his father, as his father was in prison when Malik was born and was later executed by the state. The awful things Malik was told about his father over the years caused him to feel deeply ashamed, not just of who his father was but who he was too. Malik was desperate to prove to his family that he was nothing like his father, yet the more I got to know Malik, the more I realized that after years of emotional abuse, he had very much begun to believe he was like his father, as his mother had always told him.

In the little I knew about Malik, I gathered, that like so many youth, he was egregiously neglected by our society’s safety net- those people and institutions that were supposed to care for

and protect him. I wondered how a young boy could stop going to school and no one noticed? How a family could live out of cheap motels for years? How Malik could be in a situation in which he was sexually abused? How Malik's mother was not provided the support and care she needed to take care of herself and her children? It made me wonder what happened to Malik's mother and his father in their own lives, before Malik was even born. I wondered about the trauma and pain that both his parents had experienced and how that trauma and pain was linked with systemic injustices, such as oppression and poverty.

In our case management work together, Malik and I became therapeutically aligned. We built a strong relationship. He shared with me some of his drawings and we went on hikes together, both of which helped us to deepen our connection together. He made progress in developing competencies around daily living skills such as cooking, taking public transportation, managing his time and accessing resources. He obtained food stamps and health insurance. Malik also developed friendships with his peers, which was developmentally important for him, as he had never really had friends before.

Yet with all his progress Malik struggled to fully stabilize. Once he gained the confidence to apply for jobs, it was difficult for him to obtain employment as he had limited skills and difficulty expressing himself effectively in an interview. Although he wanted to further his education, he was inconsistent in following through on obtaining his GED, which included pre-GED classes and meeting with a tutor. Malik was deeply ashamed that he had not been in school since the 7th grade, which made anything to do with education highly triggering for him. On top of Malik's many personal challenges, all the result of complex trauma, he was a young African American male experiencing homelessness in a society that stigmatizes, marginalizes and criminalizes people like him. Malik would often report being harassed by

police for simply walking down the street and he amassed many tickets for jay-walking and “jumping the train” (not paying for the train). Many of Malik’s tickets carried monetary fines but due to his lack of income he could not pay the fines, which in turn caused him more problems, including court warrants, often placing further barriers in his way.

In the years that I worked with Malik, he would often stabilize in a housing program for a period of time but would then engage in behavior (i.e. not following the program rules, getting into a conflict, using substances etc.) which would cause him to lose his housing, thus plummeting him into crisis. It should be noted that virtually all the behaviors that resulted in Malik losing his housing were symptoms of complex trauma, from Malik not being able to fully understand cause and effect and plan for the future, to his difficulty in managing and regulating his emotional and behavioral responses, to not believing in himself and his ability to accomplish his goals. With every episode of street homelessness, Malik became more vulnerable and desperate and his mental health and physical wellness decompensated.

Unable to get into shelter Malik began to use drugs more regularly and joined a gang for protection. Like many young people living on the streets, particularly young African American males, he was targeted by police. His survival behaviors led him to a string of arrests and jail time, ultimately causing him to spend an extended period of time in prison, where his mental health decompensated further than ever before. In so many ways, Malik was a product of the horrific systemic injustices that exist in our society, injustices that are the foundation of the trauma he was exposed to as a child and injustices that now, as a young African American man, continued to cause trauma and pain for him. When reflecting on youth like Malik, I cannot help but become intensely outraged. For while Malik could begin to connect, heal and transform

through his engagement in case management services, in many ways it was not enough to counteract the injustices so pervasive throughout society.

Youth Resiliency and Social Justice Youth Development

In its commitment to grassroots social work practice, this project understands the youth homelessness crisis as a social justice issue, one directly connected to the systemic injustice. To this end, the goals of this project - connection, healing and transformation - are sought not only individually within the case management process (i.e. the youth- case manager relationship, development of life skills, the transition out of homelessness, etc.) but are also relevant to this project's commitment to creating broader social change. The engagement in social action can be healing and transformative for both youth and case managers (Bloom 1997; Ginwright & Cammarota, 2002; Herman, 1992). For purposes of this project, resiliency is conceptualized as "the ability to not only cope with conditions related to adversity and injustice but also to challenge their very existence" (Prilleltensky & Prillertensky, 2005). In its commitment to radical trauma practice this project aims to build resiliency among both youth and case managers, through their engagement in social action, all in effort to challenge, disrupt and eliminate systemic injustices.

In honoring and applying a more expanded notion of trauma, one that moves beyond helping to "heal" the individual young person, to transforming our society into one that is more safe, equitable and just, and thus far less traumatizing, the utilization of the Social Justice Youth Development (SJYD) approach with young people is extremely valuable (Ginwright & Cammarota, 2002). SJYD is a youth development approach that recognizes and responds to the social context, particularly the forces of oppression impacting young people, and supports them in taking an active role in creating social change (Ginwright & Cammarota, 2002). Ginwright

and Cammarota (2002) maintain that “by focusing on the societal context of young people’s experiences, we [case managers] enhance our knowledge of how they [youth] navigate and respond to the oppressive forces that affect their lives” (p. 85). Because this project recognizes trauma, including youth homelessness, as the result of larger systemic injustices in society and in turn seeks to eliminate those injustices, SJYD is an invaluable approach, as it embeds social change within our case management practice with young people (Ginwright & Cammarota, 2002).

Ginwright and Cammarota (2002) state that SJYD seeks to “examine how their [youth’s] supports, opportunities, and risks are circumscribed by the larger political, economic, and social forces. These forces often create intense social, political and economic pressure that profoundly affect young people’s physical, emotional, and psychological wellbeing” (p. 85). As case managers working with young people experiencing homelessness, we are all too aware of how larger political, economic and social forces, have contributed to young people experiencing trauma and homelessness. In working with young people, we know that these forces cause among other things, economic inequality, racial segregation, community violence, criminalization, educational inequity, unemployment, health disparities, victimization, exploitation, discrimination and subordination, all of which deeply impact the lives of the young people we work with. A social justice youth development framework empowers young people and their case managers, to recognize, understand and address those forces, which ultimately helps in addressing youth homelessness.

The SJYD model aligns well with a youth-centered, strengths-based, trauma-informed case management practice. Ginwright and James (2002) identify five general principles of SJYD: 1.) *analyzing power within social relationships*, 2.) *making identity central*, 3.) *promoting*

systemic change, 4.) encouraging collective action and 5.) embracing youth culture. These principles are intentional, as they all empower young people and case managers to recognize, understand and address the root causes of pain, trauma, isolation, inequity and injustice experienced by youth in society (Ginwright & Cammarota, 2002; Ginwright & James, 2002). In practice, these principles range from young people developing an awareness of and celebrating their own multiple identities to learning about societal power and privilege to allowing young people to determine what is important to them and how best to connect with them (as youth), to participating in efforts to end systemic injustices through community organizing and social action (Ginwright & James, 2002). Furthermore, Milburn et al. (2010) states “interventions (i.e. SJYD) that increase racial/ethnic identification may help protect minority young people from the deleterious effects of discrimination and help them to return to more stable living situations that are more conducive to positive health outcomes” (p. 66).

Central to SJYD are the concepts of *critical consciousness* and *social action* (Ginwright & Cammarota, 2002). Ginwright and Cammarota (2002) describe critical consciousness “as an awareness of how institutional, historical, and systemic forces limit and promote the life opportunities for particular groups [i.e. youth of color, LGBTQ youth, undocumented youth, etc.]” (p. 87). As case managers, our role is to create and hold a space that encourages young people to explore and develop their own critical consciousness. I have done this through individual conversations with youth, as well as introducing young people to quotes, books and films that they can relate to and that helps tap them into their own critical consciousness.

In my experience, assisting young people in developing critical consciousness, while crucial, can be intellectually and emotionally exhausting for them. Young people can become overwhelmed, frustrated, angry and triggered when they begin to recognize, understand and

name the multiple systemic forces that have often limited their opportunities. As case managers, we must be prepared for these emotions and reactions and create a safe and affirming space for young people to process their emotions and reactions, while also helping to empower them to move forward and take action (Ginwright & Cammarota, 2002; Herman, 1992). SJYD maintains that critical consciousness encourages meaningful and intentional social action, such as community organizing and activism, which can create real and sustained social change in the lives of young people (Ginwright & Cammarota, 2002). Ginwright and Cammarota (2002) maintain that “critical consciousness and social action provide young people with tools to understand and change the underlying causes of social and historical processes that perpetuate the problems they face daily” (p. 88). In essence SJYD serves a dual purpose; it builds young people’s capacities and skills and then empowers them to engage in social action, thus working to alter the systemic forces that cause them so much disconnection, pain and trauma.

In many ways, the practice of critical consciousness within the SJYD framework is a parallel process. We as case managers, must also explore and build up our own critical consciousness as well. We must reflect and examine how “institutional, historical, and systemic forces” have limited or promoted our own “life opportunities”. For me, the development of my own critical consciousness, especially as an individual who experienced many life opportunities because of institutional, historical and systemic forces, has been essential. The ongoing development of my own critical consciousness has helped me understand how I show up in a space with young people. This in turn has helped me connect authentically with young people and has allowed me to serve as a strong, intentional and respectful ally with young people as we work for justice and equity.

According to Ginwright and James (2002), SJYD examines how young people “contest, challenge, respond to and negotiate the use and misuse of power in their lives” (p.35), particularly forms of power that heighten their own vulnerability and marginalization, such as racism, sexism and classism and how those forms of power are embedded into institutions and policies. It should be noted that we as case managers, as well as the systems of care charged with supporting young people, such as child welfare agencies and homeless shelters, can also use and misuse power in a young person’s life. As case managers working for greater justice and equity in partnership with youth, we must be open and willing to be contested and challenged by young people. We must push ourselves and the agencies we work with to eliminate practices and policies that isolate, control, subordinate and marginalize young people. For if we as case managers or agencies are misusing power in an effort to “control” or “subordinate” young people, how can we then credibly work alongside young people in their action against broader issues of injustice affecting them, such as racial discrimination, mass incarceration, immigration, unemployment or anti-LGBTQ violence.

This became clear for me when working with a drop-in center’s youth leadership council several years ago. Part of my work with the leadership council was to encourage and support the youth in taking social action around an issues that were important to the young people accessing the space. In working closely with the youth, I had assumed they would want to address and organize around access to safe and LGBTQ inclusive shelters, police misconduct or harassment in the community. Instead, youth elected to address the center’s policy on restricting/banning youth from services. It was a policy that was punitive and ultimately harmful to the young people. In many ways, I should not have been surprised by the leadership council’s willingness to take on this issue, as I had been incorporating SJYD with them for many months. In fact, most

of our meetings centered around exploring issues of injustice they were experiencing daily, particularly racism, homophobia, transphobia and violence. The youth leadership council meetings became a safe space for the youth to process with each other their experiences of oppression and injustice, thus further developing their individual and collective critical consciousness.

In electing to organize against the center's policy of restricting/banning youth from services, the youth were "contesting, challenging and responding" to the misuse of power (in their perspective) from an agency that was supposed to provide them services and support, an agency that was created to be a refuge in a hostile and oppressive society. The young people realized, as did I, that this misuse and abuse of power, was deeply harmful to their peers trying to access much needed services such as, food, clothing, counseling and a safe place to rest and be themselves. In conversations with the young people, it became clear that they saw the policy as a way to control and subordinate them within the space, which for many young people already controlled and subordinated by systemic injustice, particularly by institutional racism, homophobia and transphobia, was re-traumatizing.

After I helped them process their feelings and thoughts around the center's current system in place for holding youth accountable for their problematic behaviors, which resulted in restricting/banning youth, we began to brainstorm ways to address this concern. The youth leadership council's ideas ranged from organizing a sit-in and purposely breaking the rules, to creating a petition demanding change, to requesting a meeting with the center administration. In the end, the youth decided to partner with a local grassroots advocacy organization to develop a restorative justice approach to replace the punitive and harmful policy of restricting/banning youth for problematic behavior. This partnership became very meaningful and productive for the

youth leadership council. The bulk of our work together that year was dedicated to creating a restorative justice model that could be used at the center to replace the punitive model of punishment. In the process of developing this new approach, the young people developed and enhanced their skills and in the end were able to create something that made a positive impact on the space and their peers.

As a trauma-informed case management practice, this project seeks to build up young people's resiliency through its focus on connection, healing and transformation, both on an individual level and a more global level. The application of SJYD helps in accomplishing this aim. Reflecting on my work with the youth leadership council, employing a SJYD model, helped me to connect with the young people on a deeper level as well as aligned us in working together to fight injustice within the center and subsequently in the local community. Ginwright and Cammarota (2002) strongly believe that a SJYD approach ultimately promotes healing, maintaining that "young people heal from the impact of racial and economic suffering when they comprehend and address the complex, hidden, social and economic forces fomenting their everyday challenges" (p. 92).

The application of SJYD with young people is one way in which we as case managers begin to challenge the systemic injustices that the young people we work with must confront daily. This approach empowers our young people, through building their skills and capacities, which simultaneously works to rectify some of the impairments caused by complex trauma (i.e. self-concept, cognition, etc.). Furthermore, as Ginwright and Cammarota, indicate, for young people who have survived trauma, such as racial or economic suffering, their engagement in disrupting the systems of power that have caused this trauma and suffering can be both healing and transformative (Bloom, 1997; Ginwright & Cammarota, 2002; Herman, 1992).

Case Managers Are Social Change Agents

The focus on case manager wellness and resiliency and its connection to social action is a unique aspect of this project. In my experience, along with creating positive social change, the participation in social action builds our wellness and resiliency as case managers, which helps to mitigate the secondary trauma and burnout that working with trauma survivors can cause (Herman 1992; Prilleltensky & Prilleltensky, 2005; van Dernoot Lipsky, 2009). This makes being an agent of social change critical to our long-term survival as trauma-informed case managers (Herman, 1992; Prilleltensky & Prilleltensky, 2005). Dr. Judith Herman maintains that therapists/case managers that engage in social action because of their work with individuals, “report a sense of higher purpose in life and a sense of camaraderie that allows them to maintain a kind of cheerfulness in the face of horror” (Herman, 1992, p. 153). Just like the youth, case managers also heal from being exposed to “racial and economic suffering” and all other forms of trauma when they “comprehend and address the complex, hidden, social and economic forces” that cause and perpetuate this suffering and trauma (Ginwright & Cammarota, 2002, p. 92).

As agents of social change, case managers working in partnership with young people can educate, agitate, lobby and organize around youth homelessness and other issues of social justice impacting young people such as racial and economic equity, LGBTQ inclusion and equality, immigration, criminal justice, child welfare, affordable housing, access to healthcare, police brutality, community violence and gentrification. Case managers can enhance self-awareness, by examining how their various identities and experiences impact their work with young people, as well as influence their ability to speak up and effect real change. Case managers can further their own knowledge around systems of oppression that operate within their agencies, communities, institutions and society and then actively work to abolish those systems.

As case managers, while respecting confidentiality we can talk with our friends and family about our work with young people. In sharing how remarkable the young people we work with are, we can help to put a human face on how systemic injustices and the policies that support these injustices actually effect young people. We can develop presentations and trainings, we can seek out leadership positions within our agencies and communities, we can speak up at town hall meetings and we can show up at rallies and protests. And we can use our training, our experiences, our voices, our bodies and our hearts to make positive social change, a change that promotes inclusion, wellness, healing, equity, justice and dignity for not just youth experiencing homelessness, but for all youth, families and communities facing injustice.

The actions that we take to both comprehend and address trauma and injustice help us counteract the effects of secondary trauma, allowing us to continue to do the everyday work with young people experiencing homelessness (Prilleltensky & Prilleltensky, 2005; van Dernoot Lipsky, 2009). Some of the actions that I have taken over the years to enhance my own resilience has been attending and presenting at conferences, networking with other providers and activists that work with youth experiencing homelessness, developing my own case management practice further, becoming involved in a restorative justice initiative within the local community, writing op-eds on youth homelessness, becoming involved in anti-racist movements and working to end mass incarceration. My involvement in these “resiliency building” activities have been essential to my own wellness and ability to do the work, as it often informs, enhances and/or elevates my individual work with young people. In addition, these activities allow me to momentarily step away from the intense direct practice work with youth and engage in activities that build me up and that chip away at the systemic injustices at the root of much of the individual trauma we seek to assist young people to overcome.

The reality is that the work we, as case managers do with young people experiencing homelessness does not happen in a vacuum; it happens within a society where systemic injustice is pervasive. The work we do with young people happens in a society that has historically exhibited a significant degree of ignorance, dismissiveness and/or complicity regarding the impact that poverty, violence and oppression, has on the lives of too many young people, both on an individual and systemic level. It happens in a society in which Malik has lived out of motels, dropped out of school in the 7th grade and been subjected to emotional and sexual abuse. It happens in a society, where Malik is passed up for part-time jobs because of his lack of education and/or his skin color. It happens in a society in which many individuals and institutions are hostile towards those experiencing homelessness and stigmatizes and punishes those with mental illness and substance use. It happens in a society in which as a young African American male, Malik experiences pervasive racial discrimination, which ultimately puts him at heightened risk to be targeted by law enforcement and more likely to become incarcerated.

Furthermore, it cannot go unnoticed that many of Malik's challenges, were the result of complex trauma, which in turn takes significant time and support to manage and/or overcome. But the systems in place to assist young people like Malik, namely youth experiencing homelessness programs and organizations, are severely limited. In many cases these programs and organization are under-staffed and limited in who they can serve, what services are provided and how long youth are eligible for services. Much of the federal funding connected to housing programs for youth (emergency shelters and TLPs) require agencies to enforce time limits on how long youth can reside in housing, often forcing youth to transition or "graduate" out of housing programs before they are fully ready to be on their own. In many cases these programs and organizations cannot devote the time and resources it takes to fully assist youth in

stabilizing, which ultimately requires helping them to overcome the impairments caused by complex trauma. The limited time and resources given to these organizations is directly related to the value that we, as society place, through on our national priorities and social policies on young people experiencing homelessness, like Malik.

Our job as case managers is to connect, assist, empower and advocate for and with young people experiencing homelessness. However, many of us know from experience that this is often not enough. Prilleltensky & Prilleltensky (2005) capture this reality stating “youth workers, for example frequently do their utmost to empower young people and to instill in them a sense of control, only to realize early in the course of counseling [case management] that the environment in which marginalized youth live is much more powerful than the most sophisticated psychological intervention [case management interventions]” (p. 89). As indicated throughout this chapter the “environment” Prilleltensky and Prilleltensky (2005) refer to is one in which systemic injustice causes many young people to experience poverty, victimization and oppression, one in which social attitudes and policies have rendered their communities targeted and oppressed, their neighborhoods economically and socially isolated, their schools underfunded and neglected, their families under constant surveillance and their very bodies subjugated, policed, threatened and harmed. Prilleltensky and Prilleltensky rightly point out that we as case managers, can do everything to assist a young person to obtain employment or acquire stable housing, however, for many youth, that often is not enough in the face of systemic injustices, such as oppression and violence (Prilleltensky & Prilleltensky, 2005). The reality is that a young person can be qualified and do all the “right” things at a job interview, and still not get the job, because of their skin color or gender identity or accent.

The environmental realities that young people confront require that we as case managers not only provide individual interventions and supports for young people experiencing homelessness, but also demands that we become actively engaged in the broader movement to end systemic injustices (Bloom, 1997; McKenzie-Mohr et al., 2012). In other words, it demands that we become agents of social change. As agents of social change, we must identify, understand, respond to and address the systemic injustices that youth experience daily. We must educate others, both services providers as well as community members, about the devastating influence systemic injustice and the personal attitudes and social policies connected to these injustices have on the development, opportunities and wellness of young people. We must advocate for policies and programs that work to truly support young people and help them to heal and recover from complex trauma. We must challenge and work to eliminate the racist and oppressive attitudes, policies and institutions, that place youth like, Malik, a young African American male, at heightened risk for unemployment, homelessness, surveillance, racial profiling, victimization, incarceration and death.

Working to challenge, disrupt and eliminate the injustices that have caused and continue to cause great trauma and pain for young people, is no doubt overwhelming, as these injustices are ingrained into the fabric of our society. However, it is work that we, as case managers must fully engage in. It requires our deep and unequivocal involvement. We as case managers working with young people experiencing homelessness every day, have a unique opportunity to make a difference, not just individually with young people, but also on a systemic level. We know these young people well- their experiences, their strengths, their struggles, their passions, their dreams. We are committed to them - to their development, to their wellness, to their safety, to their visibility, to their dignity. It is our knowledge of, commitment to, and partnership

with the extraordinary young people we work with that demands we do much more than just provide them with individual case management services. We must identify, understand and address the systemic injustices at the heart of the inhumanity of the youth homelessness epidemic. And we must create spaces on all levels - individually, within agencies and communities and within society that enhance and restore young people's dignity.

Conclusion: 10 Lessons Learned

1. Establishing and sustaining safety is imperative.
2. Our relationship with young people is the foundation of all other work we do.
3. The lives of young people experiencing homelessness are complex.
4. The families and communities that young people often come from are NOT toxic.
5. At the root of trauma is systemic injustice and oppression.
6. Intentional and consistent trauma-informed practices work.
7. We must redefine what “success” looks like when working with young people.
8. We must recognize and celebrate accomplishments, however big or small.
9. Sing, dance, have fun and be human with young people.
10. Reflection and social action are essential in ending youth homelessness.

Trauma-Informed Case Management Toolkit:
Connection, Healing and Transformation

Dear Case Managers,

This trauma-informed case management toolkit is as much a philosophy as it is a collection of “tools” to be used in providing case management services to young people experiencing homelessness. The toolkit, both in content as well as in intention, seeks to address the current and future needs of youth experiencing homelessness as well as the needs of case managers working with these young people. It elevates and expands upon trauma-informed practice by understanding and responding to the crisis of youth homelessness on both an individual and systemic level, building the resiliency of both youth and case managers in the hopes that together, they can create a safer and more just society.

As you will come to learn the toolkit infuses principles of trauma-informed care, attachment theory, youth development and social justice into case management practice with youth experiencing homelessness. Broadly, the toolkit aims to enhance a young person’s strengths and personal resiliency, by focusing on: safety, relationship building, connection to resources, life skills development, social-emotional wellbeing and leadership skills. As you know, these focus areas are relevant to the unique needs and experiences of youth experiencing homelessness and their development could have a positive impact on young people.

In the spirit of trauma-informed practice, this toolkit also seeks to address the challenges faced by you, as a case manager, particularly the emotional impact of working intimately with youth who have experienced extensive trauma. As case managers, you know all too well the substantial threat secondary trauma can have on both yourselves as well as the young people you work with. The toolkit recognizes this threat and aims to minimize it by providing support to you, particularly through offering information and tools, thus building your capacity to become change agents within your agency and community. The focus on resiliency and leadership for

both you, as a case manager, and the young people with whom you work, through community engagement and social action is a hallmark of the toolkit. In providing case management services to young people, you know all too well that our response to youth homelessness must not only target the individual youth but also address the larger, systemic issues that drive the epidemic in the first place. It is my hope that this toolkit motivates case managers in applying trauma-informed practices in the larger social, cultural and political context and encourages social action to address the systemic injustice and promote broader healing, wellness and justice.

In the end, it is my sincere hope that this toolkit will inspire you to reimagine what it means to provide case management services to young people experiencing homelessness, for this toolkit is much more than just providing you with “tools” (i.e. case plan, budgeting form, etc.) to use in case management with young people. Ultimately, this toolkit encourages a paradigm shift in the way case management services are understood and provided to youth experiencing homelessness. It is a shift that is rooted in a trauma-informed practice, emphasizing connection, healing and transformation on both an individual and global level, a shift that places your relationship with the young person at the center of everything you do as a case manager, a shift that realizes that everything you do can be therapeutic, from safety planning to job searching to painting nails together, and a shift that acknowledges the significant role that case management services play not just in the lives of individual young people, but in creating social change and eventually ending youth homelessness.

Attachment Theory

Attachment Theory: The connection or “attachment” between children and their caregivers and how that attachment is developed or strengthened over time.

Attachment theory maintains that the early relationship between child & caregiver is critical to the overall positive development of the child, influencing the way in which the child views self, others & the world around them.

Secure Attachment

Secure attachment occurs when the child and caregiver develop a bond that allows the child feel safe and secure. Youth with secure attachment histories value the role that attachment and relationships play in their life, are able to regulate their emotions well and view themselves and others positively.

Insecure Attachment

Insecure attachment occurs when a caregiver is unable or unwilling to establish a secure base for the child, limiting the child’s ability to feel safe and secure.

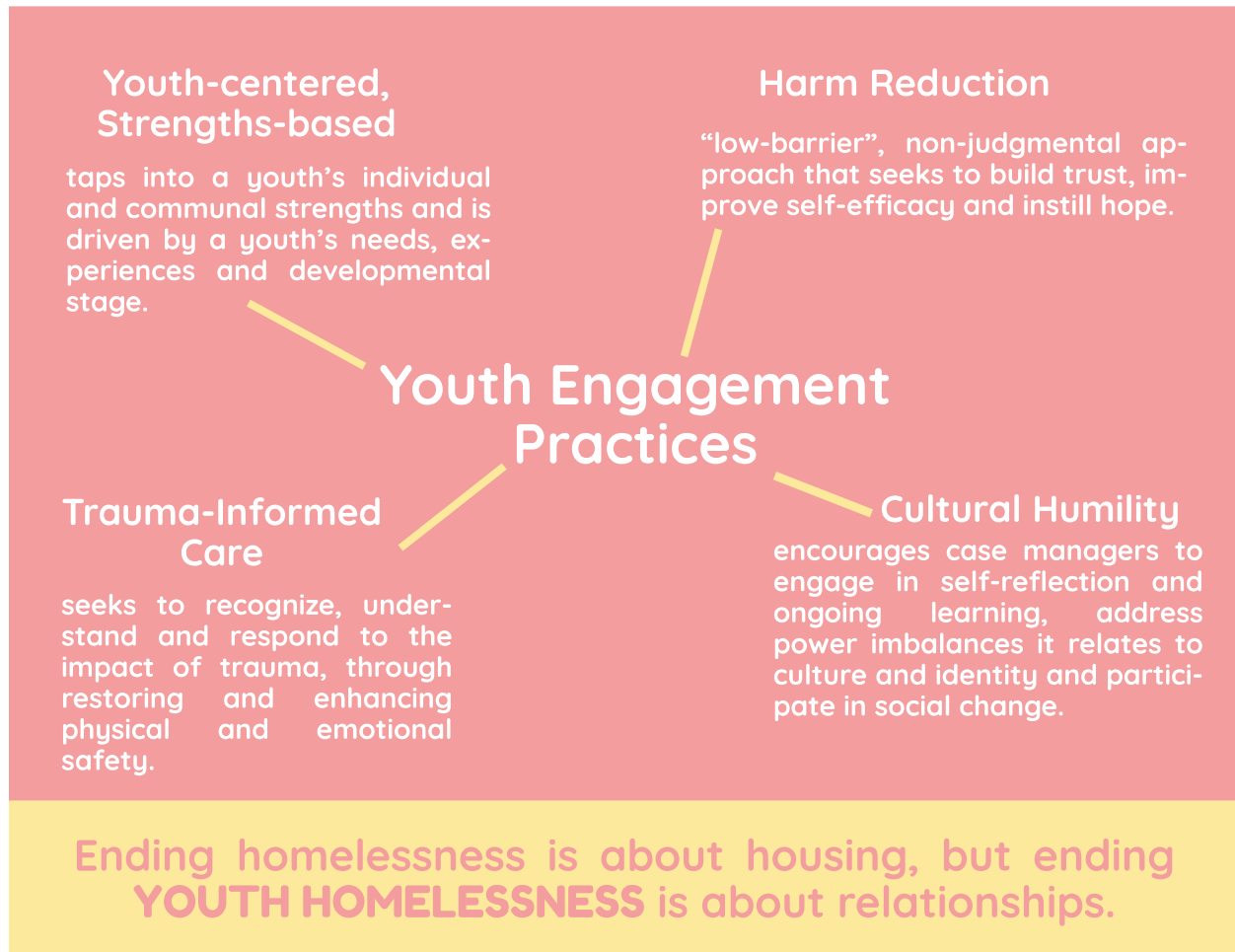
Avoidant/dismissing attachment – caregiver is unresponsive to child’s needs, leading youth to diminish or “dismiss” the importance of relationships making it difficult to build a relationship with them.

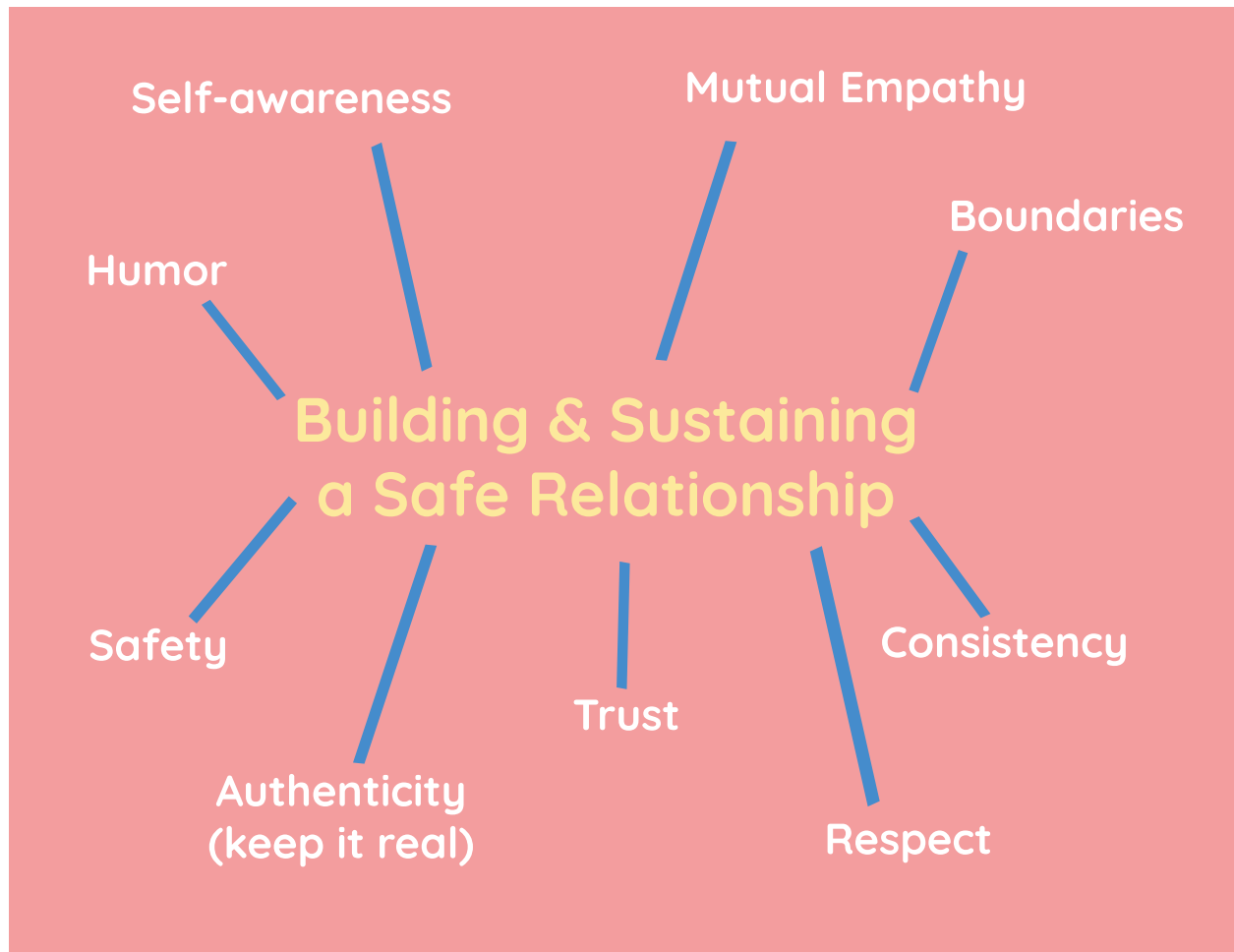
Ambivalent/preoccupied attachment – caregiver is unpredictable and/or inconsistent with child, leading youth have low self-esteem and experience anxiety around whether they are liked and accepted by others.

Disorganized/unresolved attachment – caregiver is a source of fear for the child, often due to abuse and maltreatment, leading youth to be fearful and internalize negative feelings about themselves.

“

Attachment behavior is the “propensity of human beings to make strong affectional bonds to particular others”, including case managers (Bowlby, 1977).





Trauma is both a **CAUSE** and **CONSEQUENCE** of Youth Homelessness

“

individual **TRAUMA** results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional or spiritual well-being.”

- SAMHSA, 2014

Complex Trauma

Multiple, concurrent & prolonged traumas that child/youth experience within their caregiving systems, those systems charged with caring for and protecting children/youth.

physical, emotional and sexual abuse, neglect, victimization & exploitation, family & community violence, parental substance abuse, parental mental illness & parental incarceration, poverty & housing instability and bullying, discrimination & oppression

Complex trauma deeply violates a youth’s sense of physical and emotional safety.

Complex Trauma Reshapes the Brain



Growing up in a habitual state of fear, unpredictability and stress causes youth to be in a chronic state of **hyperarousal**, leading them to operate from their “survival brain”- always ready to respond to real or perceived stress/danger.

Survival Response

automatic response when a youth experiences a real or perceived threat/danger.

Fight



Youth becomes physically activated during times of stress or danger.

(i.e. physical or verbal altercations/fights)

Flight



Youth removes themselves from the cause of stress or danger.

(i.e. avoidance, running away)

Freeze



Youth literally “freezes” or constricts movement, behavior and/or emotions during times of stress & danger.

(i.e. over compliance)

Consequences of Complex Trauma

Sense of Safety Shattered: FEAR - HELPLESSNESS - HOPELESSNESS

Attachment Behavior

Inability to develop a secure attachment, often developing a disorganized attachment style.



Difficulty in trusting and connecting with others, development of unsafe/harmful relationships.

Affect/Behavior Regulation

Difficulty in identifying, managing & regulating emotional and behavioral responses when presented with stressful or challenging thoughts, feelings or experiences.



Mood disorders, depression, self-harming behaviors, substance use, aggression, high-risk behaviors and/or oppositional behavior.

Cognition

Under-development of executive functioning skills such as information processing, planning and critical thinking and compromised personal competencies.



Difficulties in school, work and relationships, academic performance and social, development of adverse coping methods (i.e. self-harm, substance use, etc.).

Self Concept

Impaired identity development and poor self-concept.



Difficulty in identifying personal strengths, skills and talents, lack of belief in themselves, internalized negative sense of self, engagement in high-risk behaviors and increased chance of victimization.

Negative Health & Wellbeing Effects of Complex Trauma

Low self-esteem - depression - irritability - aggression - self harm - anxiety - illness - emotional numbing - memory impairment - difficulty in school & work - PTSD - high risk behavior - victimization - substance use - relationship problems - sleep disturbance - anger

Trauma-Informed Care

Trauma-Informed Care is a “strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers [case managers] and survivors [youth experiencing homelessness], and that creates opportunities for survivors to rebuild a sense of control and empowerment.” (Hopper et. al., 2010, p.82).

→ A trauma-informed approach asks youth: “What happened to you?”
Instead of: “What’s wrong with you?”

Trauma-informed care...

Realizes
deep and lasting impact of trauma and the paths to healing and transformation .

Recognizes
signs and symptoms of trauma in youth and staff .

Responds
by completely integrating knowledge about trauma, including it’s impact on both youth and staff into all policies, practices, services and interventions.

SAMHSA’S Six Principles of Trauma-Informed Care

Safety
Trustworthiness & Transparency
Peer support
Collaboration & Mutuality
Empowerment, Voice, & Choice
Cultural, Historical, & Gender Issues

Trauma-informed practices actively seeks to eliminate re-traumatization within service provision.

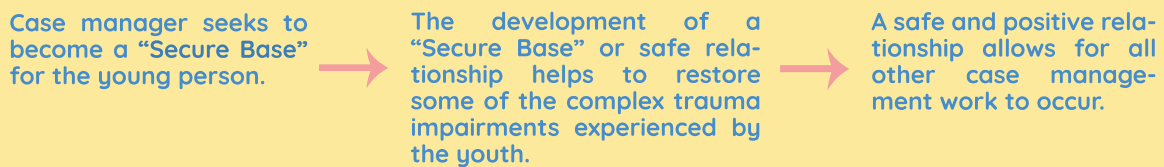


3 Core Themes of Trauma-Informed Case Management Practice

Connection

Establish and sustain a safe and positive relationship between youth and case manager.

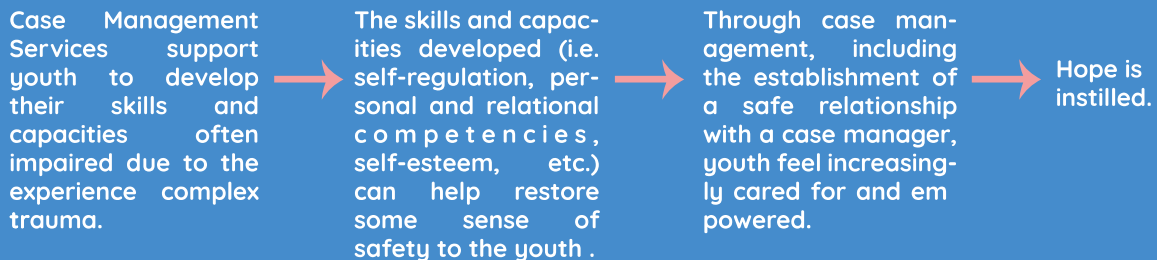
Attachment Theory, Youth Engagement, Trauma-Informed Care



Healing

Case management services can help encourage and facilitate healing.

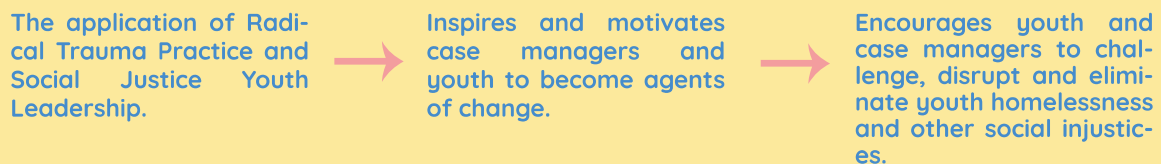
Trauma Theory, Trauma-Informed Care, Attachment Theory



Transformation

Encourage youth and case managers to recognize, understand and address larger systemic issues of social injustice.

Radical Trauma Theory, Social Justice Youth Development





USE EVERY OPPORTUNITY TO STRENGTHEN THE RELATIONSHIP WITH YOUTH

Remember all interactions
can be therapeutic.



cooking - eating meals together -
apartment searching - shopping



- protesting - college visits -

decorating cookies - crafting -



playing games - driving to

appointments - watching TV -



hiking - outreach - tutoring -

listening to music - cleaning -



celebrating holidays



WEEKLY CASE PLAN

?

Safe and Stable Housing Emergency shelter, TLP, Permanent Housing, Independent Living, Family Reunification			
Goal(s)	Youth Tasks	Case Manager Follow Up/Support	Progress/Updates

?

Employment Obtaining and Sustaining Employment			
Goal(s)	Youth Tasks	Case Manager Follow Up/Support	Progress/Updates

?

Education High School/College Planning, Enrollment, Attendance, Support and Graduation			
Goal(s)	Youth Tasks	Case Manager Follow Up/Support	Progress/Updates

?

Life Skills Development and Support of Daily Living Skills (i.e. cooking, budgeting, time manager, self-regulation, etc.)			
Goal(s)	Youth Tasks	Case Manager Follow Up/Support	Progress/Updates

?

Emotional Wellness Safety, Mental Health and Substance Use, Communication, Self-Regulation, Healthy Relationships			
Goal(s)	Youth Tasks	Case Manager Follow Up/Support	Progress/Updates

?

POTENTIAL CASE MANAGEMENT GOALS OR ACTIVITIES

Safe and Stable Housing

- Exploration, connection and follow-through on housing options (i.e. youth shelters, transitional living programs, supportive housing, section 8 housing, etc.)
- Family reunification (when safe, possible and appropriate)
- Exploration and support in independent living (i.e. renting a room/apartment)

Life Skills

- Development of basic skills (i.e. cooking, laundry, grocery shopping, etc.)
- Development of emotional/behavioral regulation (i.e. mindfulness, writing, art, etc.)
- Time Management
- Money Management & Budgeting
- Relationship building & social interaction
- Connection/access to needed resources & supports (i.e. healthcare, public assistance, SNAP, WIC, etc.)

Education

- School enrollment
- GED classes/prep
- Tutoring
- College visits/class exploration
- Career exploration
- Financial aid/FASFA assistance
- Budgeting financial aid
- Access to school supplies
- Access to transport

Employment

- Obtain legal documents for work
- Resume development
- Job exploration
- Job searching (online, in person)
- Attending job fairs
- Connection to internships
- Fill out job applications
- Interview prep (clothing, transport)
- Mock Interviewing
- Employee rights

Emotional Wellness & Mental Health

- Relationship building & social interaction
- Development of safe and healthy boundaries with family, friends, partners, etc.
- Safety planning and risk reduction
- Connection to mental health services (i.e. individual counseling, group counseling, medication, etc.)
- Substance Use prevention, counseling & treatment support
- Encouragement of self-care activities

Other

- Engagement in community service, social action or advocacy
- Engagement and follow through on risk reduction goals (i.e. substance use, survival sex/sex work, self-harm, etc.)
- Connection to mentoring
- Build up personal savings/credit

TRAUMA-INFORMED CASE MANAGEMENT ACTIVITIES

Trauma-Informed Case Management encourages a paradigm shift in what is considered “Case Management” for youth experiencing homelessness. Below are some possible case management activities that could be offered and/or facilitated by the case manager aligned with this paradigm shift and that address and/or enhance CONNECTION, HEALING and TRANSFORMATION.

Activity	Purpose	Complex Trauma Impairment Addressed	Trauma-Informed Case Management Theme
Case Manager and Youth - cook, dance, sing, write, draw, paint, craft, hike, play sports, etc.- together	Relationship building; helping youth to identify activities they are passionate about; teach new skills	Attachment, Emotional/Behavior Regulation, Self-Concept	Connection Healing Transformation
Creation of a “Vision Board”	Self-reflection; exploration of identity and beliefs; encouragement of goal setting; creation of future aspirations	Cognition, Self-Concept	Healing Transformation
Creation of a “Book of Affirmations/ Inspirational Quotes”	Self-reflection; explore and facilitate positive thinking; build resiliency; motivate and inspire	Emotional/Behavioral Regulation, Cognition, Self-Concept	Healing Transformation
Physical Exercise (i.e. running, hiking, lifting weights, etc.)	Encourage health and wellness; engage in physical activity; promote self-care	Emotional/Behavioral Regulation, Self-Concept	Healing
Yoga	Develop a connection between body, mind and spirit; promote self-care	Emotional/Behavioral Regulation, Self-Concept, Cognition	Healing Transformation
Community Outreach	Educate the community around issues of youth homelessness, help to address social injustice	Cognition, Self-Concept	Healing Transformation
Community Service	Be of service to the community; give back to community; take an active role in addressing social injustice	Attachment, Cognition, Self-Concept	Connection Healing Transformation
Participate in Poetry Slam/ Spoken Word	Self-reflection; self-expression; feeling heard; inspiring others	Cognition, Self-Concept	Healing Transformation
Create and Use Essential Oil Sprays	Promote better self-regulation; Tap into creative energies	Emotional/Behavioral Regulation, Self-Concept	Healing

TRAUMA INFORMED CASE MANAGEMENT
CONNECTION- HEALING-TRANSFORMATION

MONTHLY BUDGET

Purpose: Develop awareness and understanding around income and expenses, with the goal of supporting money management/budgeting.

Case Management Goal: Life Skills- *Money Management, Budgeting, Planning*; Safe & Stable Housing

Complex Trauma Impairments Addressed: Cognition, Self-Concept, Emotional/Behavioral Regulation

Trauma-Informed Practice: Safety, Choice, Voice, Empowerment, Transparency

Youth Name: _____

Date: _____

Monthly Income	
Wages	
Financial Aid	
Public Benefits (i.e. general relief, food stamps)	
Gifts/Allowance	
Total Monthly Income	

Monthly Expenses	
Housing/Rent	
Food	
School/Education	
Transportation	
Clothing	
Personal Items	
Fun	
Personal Savings	
Total Monthly Expenses	

Total Monthly Income: _____

Total Monthly Expense: _____

WEEKLY SCHEDULE

Purpose: Assist youth in managing time and organizing daily/weekly tasks.

Case Management Goal: Life Skills- *Time Management, Planning, Problem Solving*

Complex Trauma Impairments Addressed: Cognition, Emotional/Behavioral Regulation, Self-Concept

Trauma-Informed Practice: Safety, Collaboration, Choice, Voice, Empowerment

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
6:00AM							
7:00AM							
8:00AM							
9:00AM							
10:00AM							
11:00AM							
12:00PM							
1:00PM							
2:00PM							
3:00PM							
4:00PM							
5:00PM							
6:00PM							
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8:00PM							
9:00PM							
10:00PM							
11:00PM							

**TRAUMA INFORMED CASE MANAGEMENT
CONNECTION- HEALING-TRANSFORMAITON**

YOUTH BEHAVIOR AGREEMENT

Purpose: Encourage/support youth in correcting problematic behavior/concerning choices or upholding and/or following through on agreed to expectations, goals or behavior.

Case Management Goal: Life Skills- following through on commitments; Emotional Wellness- behavior modification

Complex Trauma Impairment Addressed: Attachment, Emotional/Behavioral Regulation, Cognitive, Self-Concept

Trauma-Informed Principles: Safety, Transparency, Collaboration, Voice, Empowerment

Youth Name: _____

Date: _____

I, _____ (youth name) agree to do my best to follow through on the following expectations/goals/behaviors:

_____ *[insert specific expectation/goal/behavior]*

_____ *[insert list specific expectation/goal/behavior]*

_____ *[list specific expectation/goal/behavior]*

I understand that my failure to follow through on the above agreed upon expectations/goals/behavior could result in the following consequence: _____ *[insert potential consequences]*

YOUTH ACTION STEPS: possible steps helpful in following through on above expectations/goals/behaviors:

- 1.
- 2.
- 3.
- 4.
- 5.

Case Manager SUPPORT: what assistance/support is needed to help youth in following through on above expectations/goals/behaviors:

- 1.
- 2.
- 3.
- 4.
- 5.

Follow-Up Date #1: _____

Follow-Up Date #2: _____

Youth Signature

Date

Case Manager Signature

Date

TRAUMA INFORMED CASE MANAGEMENT
CONNECTION- HEALING-TRANSFORMATION

RISK REDUCTION SUPPORT/SAFETY PLAN

Purpose: To enhance/support physical and emotional safety for youth, through real and honest dialogue.

Case Management Goal: Safe and Stable Housing, Life Skills, Emotional Wellness, Resource Connection

Complex Trauma Impairment Addressed: Attachment, Emotional/Behavioral Regulation, Cognition, Self-Concept

Trauma-Informed: Safety, Trust, Transparency, Collaboration, Voice, Choice, Empowerment

?

Youth Name: _____ **Date:** _____

Safety Concern:

_____ self-harm _____ suicidal ideation/action _____ violent behavior

_____ substance use _____ survival sex/sex work _____ running away

_____ sleeping outside _____ other _____

YOUTH STRENGTHS/CAPACITIES

YOUTH TRIGGERS

WARNING SIGNS/THINGS TO LOOK OUR FOR

YOUTH COPING STRATEGIES/ABILITIES

TRAUMA INFORMED CASE MANAGEMENT

CONNECTION-HEALING-TRANSFORMATION

?

SELF CARE PLANING GUIDE FOR CASE MANAGERS

Purpose: To assist the case manager in minimizing the effects of secondary trauma and burnout and promote their overall health and wellbeing.

Physical	Emotional/Mental
Social/Cultural	Spiritual

List of Further Resources

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